STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125041	A. Building B. Wing	11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liliha Healthcare Center	1814 Liliha Street Honolulu, HI 96817

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22063 Based on record review and interview with staff members, the facility did not assure documentation communicating a resident's status (i.e. contact information of the practitioner, resident representative information including contact information, advance healthcare directive information, special instructions or precautions for ongoing care, and comprehensive care plan goals) to ensure a safe and effective transition of care was provided to the receiving health care institution for two Residents (R) 5 and R6 of four residents reviewed. Findings include: 1) Cross Reference to F726: Competent Nursing Staff. The facility did not ensure a resident's physician was notified of a change in health status to assure proper treatment and follow-up was done. Resident (R)5 was transferred to an acute hospital for medical evaluation on 12/13/22 due to oxygen desaturation and shortness of breath. Review of the medical record found no transfer summary. On 01/04/23 at 04:17 PM interviewed Registered Nurse (RN)1. RN1 reported the facility uses an SBAR (Situation Background Assessment Report) to communicate with physician and emergency responders to notify them of the resident's current status. RN1 confirmed there is no documentation in the electronic health record an SBAR was completed. On 01/05/23 at 02:35 PM an interview was conducted with RN2. RN2 prepared R5 for transfer to acute hospital. RN2 reported verbal information is provided to the emergency responders. 39853 2) R6 was [AGE] year old female with Type 2 diabetes, hypertension, and history of intracranial hemorrhage. She was transferred to a hospital on 12/16/2022 after a change in condition by Emergency Medical Services (911), where she was admitted with a diagnosis of acute kidney injury (AKI, is a sudden episode of kidney failure or kidney damage that happens within a few hours or a few days). (continued on next page)

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

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/05/2023 at 02:29 PM, during an interview with RN2 she said when she transfers a resident to the hospital, she gives a verbal report to the receiving facility which would include the latest vitals and reason for transfer. She said she not aware of the need to complete an event report or send any additional documentation/information to the receiving facility. RN2 confirmed she did not complete an SBAR form.

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F 0726 Level of Harm - Actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853 Based on interview with staff members and record review the facility failed to demonstrate that all nursing staff possessed the competencies and skill set necessary to identify a change in condition and provide nursing and related services to meet the needs of one of three residents (Resident (R)5) sampled to maintain her highest practicable physical well-being. Nursing staff failed to document they report to the physician that R5 had a trend of hypotensive (low blood pressure) episodes. On [DATE], R5 fell and was diagnosed with a fractured right (R) hip, nursing staffs' initial and ongoing assessments while R5 remained in the facility (over eight hours) until non emergent transfer to the Emergency Department, failed to include assessment of the skin or pulse of the affected extremity. At the time of transfer, R5 was assessed to have diminished pulse of the extremity and it was cold to touch. R5 expired at the hospital prior to going to surgery. The lack of nursing skill set to properly assess and respond to R5's needs and delay in transfer resulted in harm and may have contributed to her death. Findings include: The Office of Healthcare Assurance received the initial Facility Incident Report (ACTS # 9868) that R5 fell on [DATE]. An updated report included the following: Resident assessed at the time of fall with resident complaint of Right side hip/low back pain. resident assisted [sic] back to bed with 1:1 supervision while awaiting Mobile imaging services. Images revealed R Hip fracture(fx). Orders given to send resident to ER for further evaluation and treatment. Update: Resident expired at acute hospital before going into operating room for hip surgery. R5 was a [AGE] year old female who had lived at the facility since [DATE]. Her pertinent medical history included Alzheimer's, hypertension, age related physical debility, Type 2 diabetes, insomnia, gastro-espohageal reflux, muscle weakness, dysphasia, and unsteadiness on feet. R5 used a front wheel walker (FWW) and frequently ambulated the halls. She was on losartan 25 milligrams (mg) and metoprolol 100 mg once a day for high blood pressure. The medication order for these two medications included criteria to hold the medication if R5s blood pressure was less than 100 systolic (top number) blood pressure. Review of R5's Records revealed the following: [DATE] Physician (MD)1's Progress note documented: ongoing significant weakness. Medication Administration Record (MAR) revealed R5 had her two blood pressure medications (losartan and metoprolol) held four out of nine days during the time period of [DATE] through [DATE] for low blood pressure. There was no documentation of repeat blood pressure, assessment if R5 was symptomatic, or notification of the trend to the physician. [DATE]: BP [blood pressure] ,d+[DATE], Not administered: On hold [DATE]: BP ,d+[DATE], Not administered: On hold (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	[DATE]: BP ,d+[DATE], Not administered: On hold [DATE]: BP ,d+[DATE], Not administered: On hold Time frame of pertinent events related to R5's fall on [DATE]: [DATE], 02:55 PM Nursing notes: Witnessed fall from standing position while using FWW. Did not hit head. restless after fall .1:1 supervision. [DATE], 03:45 PM Nursing note: vomited 1x; lab and x-rays ordered. Medication given for nausea/vomiting. [DATE], 03: ,d+[DATE]:45 PM Nursing note: ETA (estimated time of arrival) imaging 05:00 PM. [DATE], 07:30 PM Nursing note: x-rays done [DATE], 08:30 PM Radiology report signed with impression: acute right hip fracture. It is unknown what time the facility received the report. [DATE], 09:25 PM Nursing note: Notified MD1 of x-ray result. Ordered transfer to the Emergency Department. [DATE], 11:30 PM Nursing note: Scheduled transport with . ETA 11:30 PM [DATE], 11:50 PM Nursing note: Right LE (lower extremity) appears pale, cold, clammy to touch, diminished pedal pulses ., ambulance came in at 11:35 PM, Left facility at around 11:50 PM. [DATE] ([DATE] PM 07:29 PM Recorded as late entry) by MD1: D/C (discharge) --fell R HIP PAINS= = R HIP FRACTURE/N/V LATER = = TO ER ASAP X-rays were not done in a timely manner, the results of the x-rays were not provided to the MD1 in a timely manner and the transfer to the hospital was not done in a timely manner. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 01:00 PM, during an interview with Registered Nurse (RN)1, inquired what the practice was if a blood pressure medication was held due to low blood pressure outside the physicians defined parameter. She said they are supposed to recheck the BP, document the second reading, and if way high or low, would notify the physician. RN1 went on to say that some residents are asymptomatic even if their blood pressure is low, but if it continues .to be low daily, at least two to three days, would usually call the physician, and document it in the progress notes. RN1 further stated they (RNs) just follow the parameters identified by the physician. RN1 was assigned R5 the day of the fall. She said R5 spoke Korean, and uses mostly gestures to communicate. Her baseline is oriented to self only. RN1 said she assessed R5 after the fall and did not see any signs of fx. She checked her vitals, called the physician, gave Tylenol for pain and got an order for X-rays. RN1 said about ,d+[DATE] minutes later, R5 vomited one time. She then got an order for an oral antiemetic (for nausea and vomiting) and abdominal x-rays. RN1 said when she called for the X-rays and was told they would come at 05:00 PM. RN1 stated R5 kept wanting to stand, so had a CNA (certified nurse assistant) watching her the whole time. RN1 said when she left R5 was still sitting on the edge of the bed. When RN1 was informed R5 did not leave the facility until 11:50 PM, she said that's too long. She said she had heard her coworker was only able to notice everything when R5 was on the gurney lying down. On [DATE] at 03:10 PM, during an interview with RN2, she said she notified MD1 of P5's x-ray results. Inquired with RN2 what kind of monitoring and assessments should be done after a similar fall, RN2 stated they would monitor level of consciousness, vitals signs, assess for pain, bruising and limitation of movement. RN2 said they usually have a vendor come to the facility to do x-rays for this type of injury, who provides ETA (Estimated Time of Arrival). RN2 stated it often takes four to five hours, sometimes even seven, and then it takes one to two hours to get the results. When inquired how it was determined to transfer a resident by 911, or nonemergent ambulance, RN2 said it depends on our assessment and vital signs. RN2 said the physician will sometimes say it is OK to transfer via non emergent ambulance, depending on residents condition. She said R5 was hard to assess because she wouldn't lay down. RN2 said after X-rays are taken, they have to keep checking to see if the report has been sent. She said when she got the results, she called MD1 with the report and asked to transfer R5 to the hospital. RN2 reported the doctor said she could call the nonemergency ambulance. RN2 stated R5 had been sitting at the time, vitals were OK, and she was moving a lot in bed. RN2 said they had the LPN (licensed practical nurse) stay with R5 the entire time. She went on to say when getting ready to transfer her, R5 was able to lay down. At that time, she said she was able to check her, and the leg looked pale, was cold and moist with a weak pulse. RN2 said she checked the color of her leg and touched it earlier, but didn't document it. Inquired if RN2 notified MD1 of R5's condition at the time she left the facility, and she replied I'm not sure. There was no documentation RN2 notified MD1 of this change in condition in the medical record. Inquired if RN2 would notify the physician if a medication was held when the BP was outside the parameters identified in the MD order, RN2 stated she would not. RN2 stated the MD can see the vitals in the MAR. RN2 further stated if it happened several days in a row, we would usually update the doctor, and ask if they wanted to reduce the medication. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 02:30 PM concurrent record review and interview with Assistant Director of Nursing (ADON) was done. Inquired what should be included in the initial and ongoing assessments when a resident falls and diagnosed with a hip fx. ADON stated she would expect to see documentation of a head to toe assessment, neurological status, skin issues, notable different leg lengths, and vitals. Asked if they should document pulses and temperature of skin of the extremity, and the ADON said, Of course. ADON stated the staff should use 911 for transport of hip fractures as it would be considered a medical emergency. Concurrent review of R5's MAR with ADON, ADON validated R5's blood pressure medication had been held several times and said she would expect the staff to notify the MD in this situation. Review of the facility policy titled Notification of Changes last reviewed on ,d+[DATE] included the following: 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. Circumstances requiring notification include: 2. significant change in the resident's physical, metal or psychosocial condition such as deterioration in health, .That may include: a. life-threatening conditions, or b. Clinical complications. 3. Circumstances that require or may need to alter treatment. This may include .b. Discontinuation of current treatment due to: i. Adverse consequences. ii Acute condition. iii. Exacerbation of a chronic condition.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43414 Based on observation, record review and interview with staff members the facility failed to dispose four medications (three of the four medications were controlled drugs) from discharged residents and reconcile one controlled drug that was missing of the three controlled drugs. Findings Include: On 01/05/23 at 10:35 AM received a sealed yellow letter envelope addressed to State Agency (SA) containing an anonymous letter. The letter stated that there are unlocked narcotics in the Director of Nursing (DON) office. On 01/05/23 at 12:56 PM inquired with Registered Nurse (RN) 1 for a tour of the DON office. RN1 reported that the facility currently does not have a DON and nursing staff will sometimes use the office. Upon entering the DON office, RN19 was observed sitting behind the DON desk. Inquired with RN19 how the facility disposes narcotics and RN19 reported the incident of found medications in the DON office today, 01/05/23. RN19 reported she was looking for a charging cable in the DON office and looked in the closet. RN19 reported the closet was unlocked and cannot be locked. In the closet, RN19 found four Controlled Drug Record (CDR) forms with discharged residents names (Resident (R) 94, R63 and R32), the medication name, prescription information, and medication quantity. RN19 reported she only found three of the medications identified on the four CDR forms found and one medication is missing. RN19 confirmed the medication missing was a controlled drug, tramadol, a total of 56 pills ordered for R94. RN19 reported the three found medications, tramadol, morphine sulfate, and lorazepam in the closet were reconciled and disposed by her and RN8 after discovering the medications. On 01/05/23 at 02:04 PM interview with RN1 was done. RN1 stated it is concerning that R94's 56 ordered tramadol tablets were discovered missing. On 01/05/23 at 03:00 PM a second interview with RN19 was done. RN19 reported after she discovered the medications in the closet she informed RN1 and was directed to seek direction from a senior nurse. RN19 reported she sought RN8 and they crushed the medications, dissolved the crushed medications and liquid medication with water into depends and disposed them in the biohazard bin. RN19 reported RN8 and her signed off on the disposals. RN19 stated the medications should have been disposed of upon the residents' discharge if the physician discontinued the medication or should have went with the residents' if the medications continued to be ordered by the physician. RN19 stated the missing tramadol was discontinued so it did not go home with R94. RN19 reported she checked the medication disposal log with RN8 and there was no mention of R94's tramadol. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During record review, the four CDR forms revealed the facility received medications for R94, R63, and R32. R94's CDR form documented the facility received 56 tablets of the controlled drug tramadol on 03/03/22. R94 was discharged home on 03/29/22 and tramadol was discontinued on 03/29/22 due to it not being used. R63's CDR forms documented the facility received 120 milligrams (mg) of the controlled drug morphine sulfate received on 09/03/21 and 30 tablets of controlled drug lorazepam (unable to read date received). R63 was discharged on [DATE] to hospice level of care. R32's CDR form documents the facility received 56 tablets of the controlled drug tramadol with no received date and four of 56 tablets were administered. R32 was transferred to the emergency room for pneumonia and pulmonary embolism on 03/27/22. Review of the facility's policy and procedure Destroying Medications last reviewed on 02/12/19 documents Medications not qualifying for return to the issuing pharmacy (i.e., [that is] non-unit dose medications, medications refused by resident, and/or medications left by residents upon discharge) shall be destroyed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 43414 Based on interview and record review the facility failed to store all drugs in locked compartments and keep a Schedule II controlled drug in a separately locked, permanently affixed compartment. Findings Include: Cross to F755. The facility failed to dispose four controlled drugs from discharged residents and reconcile one drug that was missing of the four controlled drugs. On 01/05/23 at 12:56 PM inquired with Registered Nurse (RN) 1 for a tour of the DON office. RN1 reported that the facility currently does not have a DON and nursing staff will sometimes use the office. Upon entering the DON office, RN19 was observed sitting behind the DON desk. RN19 reported an incident of found medications in the DON office today, 01/05/23. RN19 reported she was looking for a charging cable in the DON office and looked in the closet. RN19 reported the closet was unlocked and cannot be locked. In the closet on a shelf, RN19 found four Controlled Drug Record (CDR) forms with discharged residents names (Resident (R) 94, R63 and R32), medication name, prescription information, and medication quantity. RN19 reported she only found three of the medications, tramadol for R32 and lorazepam and sulfate morphine (a Schedule II controlled drug) for R63, identified on the four CDR forms found. RN19 stated R94's 56 tablets of tramadol received by the facility was missing. On 01/05/23 at 02:04 PM interview with RN1 was done. RN1 reported the DON's office is not kept locked because the nursing staff use it during the day, evening, and night shift. On 01/05/23 at 03:00 PM a second interview with RN19 was done. RN19 confirmed the closet where the medications were found has a latch to close it but does not have a lock. RN19 further confirmed the office has been unlocked the last few weeks because no one knows where the office key went. Review of the facility's policy and procedure Medication Storage in the Facility last reviewed on 02/12/19 documents Only licensed nurses, the Consultant Pharmacist, and those lawfully authorized are allowed to access to medications. Medication rooms, carts and medication supplies are locked or attended by persons with authorized access .Except for those requiring refrigeration, medications are intended for internal use are stored in a medication cart or other designated area .Schedule II controlled medications are stored separately from other medications in a locked drawer or compartment designated for that purpose.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43414 Based on record review and interview with staff members the administration (administrator, governing body, and management company) failed to effectively and efficiently provide support to the facility and staff members to ensure residents attain or maintain their highest practicable physical, mental and psychosocial well-being. The facility failed to ensure all areas of the facility's Plan of Correction (POC) was corrected and/or worked toward compliance by the corrective action date the facility chose, 12/27/22, and the Directed Plan of Correction (DPOC) was completed by 12/28/22. Findings Include: 1) On 11/30/22 the State Agency (SA) sent a letter to the facility Re: COVID-19 Survey on November 15, 2022 the letter included the purpose of the survey that was conducted on 11/15/22, remedies, and information on the required POC, Informal Dispute Resolution (IDR) and Appeal Rights. As part of the remedies documented, the facility was to complete the DPOC consisting of seven items to be completed by 12/28/22. The seven items included: (1) All staff must view the training videos and the facility shall submit attendance sheets on: * COVID-19 Prevention PPE [Personal Protective Equipment] Use . * Closely Monitor Reisndet [sic] for COVID-19 . * Keep COVID-19 Out! . (2) Utilize online infection prevention training courses such as hand hygiene and glove use found in QSO 19-10 NH dated 03/11/2019, specifically, Module 5 Outbreaks, Module 6B Principles of Transmission-Based Precautions, and Module 7 Hand Hygiene. Training shall be provided by the Director of Nursing, Infection Preventionist, Medical Director, or other facility training coordinator; (3) Immediately implement an appropriate infection prevention and intervention plan which includes the Root Cause Analysis (RCA) for the affected resident(s) identified in the deficiency and consistent with the requirements of 42 CFR S483.30. The RCA will be conducted with assistance from the Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee and Governing Body. The RCA should be incorporated into the intervention plan. Information regarding RCA can be found at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf; (4) The facility shall submit the credentials of the Infection Preventionist to .[SA]; (5) Hire or contract with an infection control consultant or manager. If the consultant hired is an Infection Control Nurse (ICN)/Infection Preventionist, the ICN must have completed specialized training in infection prevention and control. The ICN will be at the facility for a minimum of six months. Further, the contract will be pre-approved in writing by OHCA within 15 days of receipt of your plan of correction; (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(6) The Infection Preventionist shall assist the Medical Director, Regional Nurse Consultant (RNC), and Regional [NAME] President (RVP) to complete the LTC infection control self-assessment. If this assessment was completed prior to the citation of harm and IJ [immediate jeopardy], the assessment should be reviewed to determine if it is a true and accurate reflection of the nursing home; (7) Submit all above training records to the .[SA] .by December 28, 2022. From 12/28/22 to 01/03/23 the facility did not submit training records or supporting documents for the DPOC or request an extension from the SA. On 01/03/23 at 09:00 AM a phone interview was made to the administrator regarding the training records and supporting documents for the DPOC that was due on 12/28/22. Administrator stated he went on emergency leave on 12/30/22 and is not in the State. Administrator further stated he instructed staff to send the supporting documents to SA and to expect it today. Inquired who is the point of contact at the facility since there is currently no Director of Nursing (DON), Administrator stated the facility's sister facility administrator (Governing Body Member (GBM) 1) and the facility's management company's [NAME] President of Skilled Nursing Facility Operations are interim the facility's point of contact. On 01/03/23 at 10:12 AM a phone interview with Registered Nurse (RN) 1 (DON for the sister facility) was done. RN1 stated she is attempting to gather supporting documents for the POC but is having difficulty locating everything. Clarified with RN1 that the facility was supposed to send the training records and supporting documents for the DPOC that was due on 12/28/22. RN1 stated she was not aware of the DPOC and has not seen the letter sent to the facility on [DATE] Re: COVID-19 Survey on November 15, 2022. RN1 stated she will attempt to retrieve training records and supporting documents for the DPOC. On 01/04/23 at 08:16 AM the SA entered the facility and requested to have an entrance conference for the onsite revisit to address the facility's non-compliance on 11/15/22. At 08:49 AM, 33 minutes later, RN1 and GBM1 arrived at the facility and an entrance conference was conducted. RN1 confirmed nothing has been submitted for the DPOC to the SA. On 01/04/23 at 11:33 AM RN1 confirmed the RCA was not included in the infection prevention plan and was not done as required from item three of the DPOC. On 01/04/23 at 03:23 PM RN 1 confirmed there is no documentation that staff members viewed the training video Closely Monitor Resident for COVID-19 required in item one of the DPOC. 2) Review of the facility's POC documented for the deficient practice in Infection Control PPE use audit will be completed on 3 random employees weekly x 4 weeks and until QAPI team deems necessary On 01/04/23 at 11:33 AM interview with RN1 was done. RN1 confirmed the facility did not do competencies for PPE use and was not able to find documentation that audits for PPE use was done. On 01/05/23 at 10:36 AM interview with Infection Preventionist (IP) was done. IP confirmed the facility did not audit staff members on PPE use. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liliha Healthcare Center	1814 Liliha Street Honolulu, HI 96817

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3) Review of the Infection Control policy and procedures received by the facility had the management company's header, not the facility's header, and the revised/reviewed dates were dated prior to the focused infection control survey on 11/15/22. During the 11/15/22 survey, the facility submitted an IJ removal plan on 11/15/22 at 01:57 PM and included in the removal plan that the facility will review and update the Infection Control policy and procedures by 11/18/22. On 01/05/23 at 03:23 PM concurrent review of the Infection Control policy and procedures and interview with RN1 was done. RN1 stated the Infection Control policy and procedures are the same ones printed on 11/15/22. RN1 confirmed the facility did not update or revise the Infection Control policy and procedure. RN1 stated the management company provides the facility a copy of their policies and procedures for guidance but the facilities are responsible for changing the header to their facility name, and review/ revise the policies and procedures based on facility's State and tailor it to the facility. 4) Cross Reference to F865. The facility failed to provide evidence that the facility has a functional Quality Assurance and Performance Improvement (QAPI) program. The facility failed to provide documentation the QAPI committee reviewed the corrective actions described in the facility's POC. Review of the facility's POC documents the QAPI committee will review audits for blood pressure screening and medications, hand washing competency, Personal Protective Equipment (PPE) use, new admissions and monthly summary for vaccinations, COVID-19 testing, and COVID-19 vaccination status. The POC documented the QAPI committee reviewed and updated the facility's policies regarding COVID-19 and infection control practices on 11/28/22 and is to review infection surveillance data, and communication compliance for COVID-19. monthly. On 01/04/23 at 12:18 PM requested with Registered Nurse (RN) 1 to provide documentation and/or evidence that the QAPI committee discussed the POC items. The facility did not provide documentation and/or evidence.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853 Based on document review and interviews, the facility did not demonstrate there was an active (effective and involved) governing body that is responsible for establishing and implementing policies regarding the management of the facility. Minutes of meetings did not show there was an effective method of communication between the administrator, governing body and the contracted management company (MC). In addition, there was lack of evidence that the Administrator (ADM) was held accountable and reported information about the facilities management and operations directly to the governing body. Findings include: Cross Reference 726: Competent Nurse Staff. The nursing staff failed to demonstrate competency to provide safe care and according to standards of nursing practice in four residents of a sample size of five. Cross Reference 727. The facility failed to designate a registered nurse to serve as the director of nursing (DON) on a full time basis. Cross Reference 835. The administration (administrator, governing body, and management company) failed to effectively and efficiently provide support to the facility and staff members to ensure residents attain or maintain their highest practicable physical, mental and psychosocial well-being. The facility failed to ensure all areas of the facility's Plan of Correction (POC) was corrected and/or worked toward compliance by the corrective action date the facility chose, 12/27/22, and the Directed Plan of Correction (DPOC) was completed by 12/28/22. 1) The Board of Directors oversees two facilities, this facility (F)1, and F2. The facilities have a contract with a management company (MC) for both facilities. At time of this survey, the ADM was on emergency leave and unavailable. The facility also did not have a Director of Nursing (DON). Due to the fact that the documents for the were not sent to the State Agency (SA) as required, and findings of this revisit, a review of the governing board was completed. Registered Nurse (RN)1 from F2, was on site to provide support to F1 during the survey and the individual providing documents and support to the survey team. A request was made for any documents that would define roles and responsibilities of the board, management company, and ADM. The facility was unable to provide a board charter or policy document that clearly defined respective roles, responsibilities and authorities of the Board of Directors (both individually and collectively) in setting the direction, the management and the control of the facility. The facility also was unable to provide an organizational chart or any documents how the organization was structured. It was unknown what types of problems and information are reported or not reported directly to the board. The Governing board members (GBM)1 and GBM2 said the MC had direct oversight of the ADM, and that the (MC) communicates to the board. It was not clear how that communication occurs, how often and what specifically is reported, and how the board responds back (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/05/2023 at 12:02 PM during an interview with GBM2, she was designated as the board secretary. She said they meet weekly, but if members cannot attend the meeting, the meeting is held until the majority is available. GBM2 said back in November, the ADM mentioned the results of the complaint survey, based on a family members complaint regarding a fall that occurred and the resident was transferred out, and that it was reported the facility had two IJ's and a harm. At that time she said the facility had not received the survey report (2567). GBM2 said they (the board) wanted know about the 2567, and there was to be follow-up. She said she didn't see the 2567, but knew the ADM had submitted a response (Plan of Correction/POC). GBM2 said the last time they met ADM said he said there are some part of POC that had to be fixed, and said the IJ was abated. She went on to say they knew after December 20th a revisit could occur. GBM2 said the board did not get copies of the SA letters, and did not know possible consequences. She said the last time (12/19) they the POC had been resubmitted. She said [NAME] asked specifically if the facility was ready, but that it was more of an assumption we were. GBM2 confirmed meetings were held on 12/19/2022, 12/12/2022, 11/28/2022 and 11/21/2022. Inquired if the board agenda includes Quality, and she said QAPI is addressed by having copies of the report, but that doesn't occur half the time. She said the weekly meetings are 30 minutes and although QAPI (Quality Assurance Performance Improvement) is one of seven items listed on the agenda, they prioritize and usually have only time to discuss any immediate problems. When inquired if the board asked if the facility was ready for the revisit, she said it was more of an assumption we were ready. 3) Reviewed the Board minutes dated 11/21/2022, 11/28/2022 12/12/2022 and 12/19/2022. The minutes included the following: 11/21/2022 minutes: Survey Management: Surveyors visited d/t Covid outbreak. Outcome-2 Immediate Jeopardy, 1 G (actual harm), . Survey report 2567 not received; financial penalties may be involved. Former DON (Director of Nursing) has been let go; .Newly hired unit manager RN2 has stepped into DON role; . Also, a new IP nurse has been hired who can work 24 hrs. per week. Both will handle survey issues. Clinical RN from MC, will be coming out to support F1 and F2. . Dr. requesting to see P&L (profit and loss) sheet, change in personnel balance sheet, payroll, and budget for 2023. There was no documented or attached QAPI report. 11/28/2022 minutes: Census/Trend: . Also for support, MC assigned F2 DON to oversee nursing operations at F1 and F2. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 43414 Based on record review and interview with staff members the facility failed to provide evidence that the facility has a functional Quality Assurance and Performance Improvement (QAPI) program. The facility failed to provide documentation that the QAPI committee reviewed the corrective actions described in the facility's Plan of Correction (POC) for the survey date 11/15/22. Findings Include: Review of the facility's POC with a completion date of 12/27/22 documents the QAPI committee will review audits for blood pressure screening and medications, hand washing competency, Personal Protective Equipment (PPE) use, new admissions and monthly summary for vaccinations, COVID-19 testing, and COVID-19 vaccination status. The POC documented the QAPI committee reviewed and updated the facility's policies regarding COVID-19 and infection control practices on 11/28/22 and is to review infection surveillance data, and communication compliance for COVID-19. monthly. On 01/04/23 at 12:18 PM requested with Registered Nurse (RN) 1 to provide documentation and/or evidence that the QAPI committee discussed the POC items. The facility did not provide documentation and/or evidence. On 01/05/23 at 12:45 PM interview with Social Worker (SW) was done. SW stated the facility usually has QAPI minutes and it is assessable on the computer but the QAPI minutes for November and December were not posted. SW stated he does not know who created the QAPI minutes.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44942 Based on interviews, record reviews, and review of facility policies and procedures, the facility failed to have adequate knowledge of the facility's COVID-19 policies and procedures in order to effectively implement the facility's COVID-19 plan during an outbreak as evidenced by failing to established a facility-wide infection control plan including written infection control standards, policies, and procedures that are current and based on the facility assessment and national standards, failing to notify state authorities of COVID-19 cases in the facility, failing to provide education to staff on COVID-19, proper use of PPE, and hand hygiene and failing to have an infection surveillance plan in place to monitor and evaluate clusters or outbreaks of illness among staff and residents. The deficient practices placed the COVID-19 negative residents at risk for contracting the COVID-19 infection. There were four staff members and 25 residents that tested positive for COVID-19. One Resident (R)10 with a positive COVID-19 test result expired. Findings Include: Cross Reference to F882, Infection Preventionist. The facility failed to clearly identify an individual responsible for the Infection Preventionist position, failed to ensure that the IP was performing the duties of the position, including an understanding of the facility's COVID-19 policies and procedures. Cross Reference to F886, COVID-19 resident and staff testing. The facility failed to conduct testing in a manner that is consistent with current standards of practice for COVID-19 tests. On [DATE] at 08:30 AM, the Administrator was interviewed and stated that the facility had a COVID-19 outbreak two weeks ago and that there were still some residents coming out of isolation. On [DATE], a review of the facility's COVID-19 staff line list (flowsheet that shows who tested positive and date of when they were tested , COVID-19 symptoms if any and onset date, location of place last worked, and whether vaccinated or not) indicated that the following staff had been tested for COVID-19 on the following dates: Certified Nursing Assistant (CNA) 1 on [DATE], CNA2 on [DATE], Licensed Professional Nurse (LPN) 1 on [DATE], and CNA3 on [DATE]. All four staff had COVID-19 symptoms prior to being tested and subsequently tested positive A review of resident line listing (flowsheet that shows who tested positive, location of room, COVID-19 symptoms if any with onset date, PCR test results and date collected, and vaccination status) indicated 25 residents were listed as tested positive for COVID-19 from [DATE] to [DATE]. Resident (R) 24 was the first resident that tested positive for COVID-19 on [DATE] for symptoms of sore throat, cough, and increased phlegm. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 12:19 PM, Director of Nursing (DON) and DON2 (DON of the facility's sister facility) were interviewed. DON stated that she is covering for the Infection Preventionist (IP) position and had completed the Centers For Disease Control and Prevention (CDC) modules on infection prevention. DON reported she was not at the facility during the first week of the outbreak due to attending a conference and was on medical leave afterwards. DON stated the outbreak started after the first resident tested positive for COVID-19 on [DATE], R24, who receives dialysis services offsite. DON did not mention any information about staff testing positive prior to R24 testing positive. DON further stated that the facility isolated R24 and tested his roommate who also tested positive. Due to DON not available during the outbreak, DON2 stated that she was asked to come to the facility to assist with the outbreak. DON2 recommended the facility to test all the residents and staff. DON2 stated that the outbreak had started with three staff testing positive for COVID-19. DON2 confirmed four staff members and 25 residents tested positive for COVID-19. DON2 further stated that Resident (R) 10, who was still positive for COVID-19, was found unresponsive and passed away last night ([DATE]). When inquired to see the facility's infection prevention manual, DON stated that Assistant Director of Nursing (ADON) was in the next room printing it and putting it together. On [DATE] at 1:00 PM a subsequent interview was done with DON2. DON2 stated that she had previously worked as the facility's IP, but then transferred to work as the DON at a sister facility in [DATE]. DON2 reported the facility has not had an IP since then. DON2 stated that the Administrator called her on [DATE] to assist with the outbreak at this facility. DON2 reported that when she came to the facility on [DATE], there was no COVID-19 line list for staff and residents, no contact tracing done, and not enough (Personal Protective Equipment) PPE carts on the floor. DON2 further reported it took her a week to gather information on the outbreak. She stated that only the roommates of positive residents had been tested for COVID-19 and staff that had been in contact with R24 had not been tested . A total of nine residents were positive for COVID-19 when she arrived. She stated she then had all staff and residents tested , with 11 other residents testing positive. DON2 stated that she had to create the resident line list for the facility and that the facility does not have their own policies and procedures for COVID-19. DON2 explained that the facility had a general COVID-19 plan from their corporate company, but that the facility should have taken that plan and catered it the needs of their own facility. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 08:26 AM a second interview with DON was done. Inquired with DON the timeline of the recent COVID-19 outbreak at the facility, DON stated that she was at a conference offsite from [DATE] to [DATE] and while at the conference, she had received a phone text from staff reporting R24 was a presumptive positive and that there were more cases of COVID-19 in the facility. DON stated that she did not actively manage the outbreak while she was at the conference and that she was only in communication with the facility about what was happening. When inquired for documentation of the phone texts DON received from staff, none was provided. DON stated that she did not know the timeline of interventions taken for COVID-19 at the facility. When DON returned to the facility on [DATE], DON stated that she had received a call on [DATE] from the Department of Health (DOH) to follow-up on R24 whom had tested positive for COVID-19. When inquired if the facility informed the DOH of R24 being positive for COVID-19 beforehand, DON stated that she was not sure, and she did not report the positive cases to DOH. DON stated that she was on medical leave thereafter and returned to work on [DATE]. Inquired with DON what responsibilities or role she had as DON for infection control, DON stated that she was in the process of working with the ADON on the facility's infections tracker. DON stated that the DON would be responsible for reporting diseases to the DOH. When inquired what diseases she would report, DON pointed to facility's infection control binder and stated that the information was somewhere in the binder and did not specify what disease she would report. When inquired what she would do if a staff member showed signs and symptoms of COVID-19 today, DON stated that she would have the staff member sent home and tested for COVID-19. When further inquired if there would be any other steps that would be done after staff member was sent home, DON remained silent and stared at surveyor. Surveyor then asked if any contact tracing would be done. DON then stated that they would find who the positive employee worked in close contact with or had any significant exposure to. Inquired what would constitute a close contact or significant exposure, DON looked in the facility's infection control binder for a few minutes for the definition of a significant exposure. Inquired if the facility had done contact tracing for the staff who tested positive on the facility's staff line listing for COVID-19, DON reviewed the staff line listing for COVID-19 and stated that she did not know who created it. DON further stated that she was not sure if there was any documentation showing if there was any follow-up or contact tracing done regarding staff who had tested positive for COVID-19. DON confirmed that the policies and procedures for Infection Control dated ,d+[DATE] were received and printed from their corporate company yesterday, [DATE]. DON stated that they store their infection control policies and procedures on the computer and that she hasn't had time to review it. DON reported that these policies and procedures have not been reviewed by the facility's QAPI committee. When further inquired if any staff education or audits had been done regarding PPE use, hand hygiene, and COVID-19, DON was not able to confirm and said that she would look for any documentation. On [DATE] at 10:36 AM, a third interview and concurrent record review was done with DON. DON provided a schedule for [DATE], confirming that there was a conference from [DATE] to [DATE]. DON stated that the DOH called the facility to follow-up on R24 on [DATE] and another call from DOH to the facility was done on [DATE]. The calendar did not indicate that there were phone calls from DOH made on those dates. DON confirmed she did not report to DOH when staff and/or residents were positive for COVID-19 and the DOH was not initially notified by the facility of R24 when tested positive for COVID-19. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 10:48 AM and interview with the Administrator was done. Administrator stated on [DATE] he was notified that there was an outbreak of COVID-19 and that he was out of the facility two weeks prior. Administrator stated that he inquired if DON called the DOH and that the DON reported she had had already spoken to someone. Administrator understood DON was taking the lead on the recent COVID-19 outbreak. Administrator further stated that on [DATE], he received a call from the DOH reporting they received information that the facility had positive COVID-19 residents and they were trying to contact DON. Administrator stated from then he realized DON did not initially call DOH to report COVID-19 positives at the facility and DON was not following-up on the outbreak, but by then DON was out on medical leave. On [DATE] at 11:30 AM DON further confirmed that there was no documentation for audits for compliance with PPE use and hand hygiene, no staff education on PPE use and hand hygiene, and no documentation for staff training on COVID-19. DON also stated that there was no documentation on follow-up contact tracing for staff who had tested positive for COVID-19. On [DATE] at 01:12 PM, a fourth interview and concurrent record review was done with DON regarding R24's EHR, the first resident that test positive for COVID-19 at the facility. DON confirmed that R24 required dialysis services offsite every Monday, Wednesday, and Friday. DON confirmed that progress note dated [DATE] at 2:57 PM stated that resident was tested for COVID-19 due to sore throat and that resident was sent afterwards to his hemodialysis appointment. DON reviewed R24's lab results dated [DATE] at 05:48 AM which stated that R24 was tested for COVID-19 on [DATE] at 2:00 PM, with positive COVID-19 results on [DATE] at 05:48 AM. DON reviewed Dialysis Communication Record dated [DATE] and confirmed that there was no documentation on the record regarding R24 being tested for COVID-19 and that R24 left the facility for dialysis at 3:00 PM. DON stated that the dialysis facility should have been informed of R24 being tested for COVID-19 prior to R24 leaving the facility for dialysis since the dialysis facility does not accept residents who are currently COVID-19 positive. When inquired if there were any policies and procedures regarding residents who required offsite dialysis services but were being tested for COVID-19 or were positive for COVID-19, DON stated that she was not sure. Review of the facility's Infection Prevention and Control Assessment Tool for Long-Term Care Facilities (ICAR), which was conducted by Infection Control Consultant (ICC) from the Disease Outbreak Control Division at the Hawaii State Department of Health on [DATE] in response to an earlier COVID-19 outbreak at the facility. The ICAR included the following discrepancy in the facility's IP program, III. Surveillance and Disease Reporting and IV. Hand Hygiene. The ICAR documents the facility does not have .a written surveillance plan or policy outlining the activities for monitoring/tracking infections occurring in residents of the facility . and .all personnel receive training and competency validation on HH [Hand Hygiene] at the time of employment and within the past 12 months. It was recommended for the facility to Include Hand Hygiene in orientation.

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F 0882 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44942 Based on interviews and record reviews, the facility failed to properly prevent and contain COVID-19 as evidenced by failing to clearly identify an individual responsible for the Infection Preventionist (IP) position, failing to ensure that the IP was performing the duties of the position and demonstrated understanding of the facility's COVID-19 policies and procedures. The deficient practice puts all residents at risk of infection diseases, including COVID-19. Four staff and 25 residents tested positive for COVID-19. One Resident (R)10 with a positive COVID-19 test result expired. Findings Include: Cross Reference to F880, Infection Prevention and Control. The facility failed to have adequate knowledge of the facility's COVID-19 policies and procedures in order to effectively implement the facility's COVID-19 plan during an outbreak as evidenced by failing to establish a facility-wide infection control plan including written infection control standards, policies, and procedures that are current and based on the facility assessment and national standards, failing to notify state authorities of COVID-19 cases in the facility, failing to provide education to staff on COVID-19, proper use of PPE, and hand hygiene and failing to have an infection surveillance plan in place to monitor and evaluate clusters or outbreaks of illness among staff and residents. Cross Reference to F883, Influenza and Pneumococcal Immunization. The facility failed to offer updated influenza and pneumococcal immunizations to four residents. The facility's policy and procedures document the IP responsible for ensuring the pneumococcal vaccination was given or offered to residents and documented. On [DATE] at 08:30 AM, the Administrator was interviewed and stated that the facility had a COVID-19 outbreak two weeks ago and that there were still some residents coming out of isolation. On [DATE], a review of the facility's COVID-19 staff line list (flowsheet that shows who tested positive and date of when they were tested , COVID-19 symptoms if any and onset date, location of place last worked, and whether vaccinated or not) indicated that the following staff had been tested for COVID-19 on the following dates: Certified Nursing Assistant (CNA) 1 on [DATE], CNA2 on [DATE], Licensed Professional Nurse (LPN) 1 on [DATE], and CNA3 on [DATE]. All four staff had COVID-19 symptoms prior to being tested and subsequently tested positive A review of resident line listing (flowsheet that shows who tested positive, location of room, COVID-19 symptoms if any with onset date, PCR test results and date collected, and vaccination status) indicated 25 residents were listed as tested positive for COVID-19 from [DATE] to [DATE]. Resident (R) 24 was the first resident that tested positive for COVID-19 on [DATE] for symptoms of sore throat, cough, and increased phlegm. (continued on next page)

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F 0882 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 12:19 PM, Director of Nursing (DON) and DON2 (DON of the facility's sister facility) were interviewed. During this interview, DON stated the facility does not have a dedicated Infection Preventionist (IP) position but has completed the Center for Disease Control and Prevention (CDC) modules on infection prevention and is covering for now. DON further stated the Assistant Director of Nursing (ADON) will eventually be taking on the role of IP and is in training to be a certified IP. DON reported she was not at the facility during the first week of the outbreak due to attending a conference and was on medical leave afterwards, returned to work on [DATE]. Due to DON not available during the outbreak, DON2 stated that she was asked to come to the facility to assist with the outbreak. DON2 confirmed 4 staff and 25 residents total tested positive for COVID-19 and a resident, R10, who was still positive for COVID-19, was found unresponsive and passed away last night ([DATE]). When inquired to see the facility's infection prevention manual, DON stated that ADON was in the next room printing it and putting it together. On [DATE] at 1:00 PM a subsequent interview with DON2 was done. DON2 stated that she had previously worked as the facility's IP, but then transferred to work as the DON at a sister facility in [DATE]. DON2 stated that the facility has not had an IP since then. DON2 reported that the current ADON was hired recently and was not IP certified and the DON was never supposed to be the IP. DON2 further reported during an assessment done by an Infection Control Consultant (ICC) from the Disease Outbreak and Control Division at the Hawaii State Department of Health in the summer, the DON informed the ICC she was not going to be the IP. DON2 stated that the Administrator called her on [DATE] to assist with the outbreak at this facility. DON2 reported that when she came to the facility on [DATE], the facility did not implement the facility's COVID-19 plan due to not developing a facility COVID-19 plan and/or policy and procedures to prevent and control the COVID-19 outbreak. On [DATE] at 1:50 PM, a concurrent record review and interview was done with ADON. ADON stated that on [DATE], the facility asked her to assume the role of infection preventionist and that she could work under the DON who was IP certified, until ADON was certified herself. ADON reviewed and confirmed that the facility's infection prevention policies dated ,d+[DATE], were directly from their corporate company. ADON stated that she was not familiar with the facility's infection prevention policies, and they were printed today. On [DATE] at 08:00 AM, a record review was done of the facility's Infection Prevention and Control Assessment Tool for Long-Term Care Facilities (ICAR), which was conducted by an ICC from the Disease Outbreak and Control Division at the Hawaii State Department of Health on [DATE] in response to an earlier COVID-19 outbreak at the facility. The ICAR stated the following discrepancy in the facility's IP program for I. Infection Control Program and Infrastructure .Elements to be assessed: A. The facility has specified person (e.g. staff, consultant) who is responsible for coordinating the IC program .Assessment: Yes .Notes/areas for improvement: Need an IP (continued on next page)

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F 0882 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 08:26 AM, a second interview and concurrent interview was done with the DON. Inquired about the facility's ICAR and DON stated that she had informed ICC and Administrator that it was not realistic for herself to be both the IP and DON at the facility. DON stated that she has worked at the facility as the DON since [DATE]. DON stated that the facility previously had an IP consultant, but the contract had ended. DON stated that she was qualified to be an IP and that the facility was currently in the process of having the ADON become IP certified and assume the role of IP. DON confirmed the facility does not currently have a staff member in the IP position and reiterated she was clear with Administrator she cannot take on the role. When inquired what responsibilities DON had for infection control, DON stated that she was in the process of working with the ADON on the facility's infections tracker and would be responsible for reporting diseases to the state department of health. When inquired what diseases she would report, DON pointed to facility's infection control binder and stated that the information was somewhere in the binder and did not provide surveyor diseases she would report. DON stated the facility did not have COVID-19 policies in place when she started working at the facility. DON confirmed that the facility's infection prevention policies dated ,d+[DATE], were directly from their corporate company and were printed yesterday, [DATE]. DON stated that she has not read and is not familiar with the facility's infection prevention policies because they are stored in the computer and has not had time to review it. Due to the facility not having a dedicated IP, DON reported no one can speak into the policies and the policies have not been reviewed by the facility's Quality Assurance and Performance Improvement (QAPI) committee. On [DATE] at 10:48 AM, Administrator was interviewed. Administrator stated that the DON was hired in [DATE] and that the facility did not have an IP at that time. When inquired who the facility's IP was, Administrator stated the DON was certified to be an IP and the ADON is in training to be the facility's IP under DON. Clarified with Administrator if DON agreed to take on the role as IP, Administrator stated that DON was responsible for making sure that all the infection control policies were followed, and that DON was responsible for delegating the IP role as necessary. During the most recent COVID-19 outbreak, Administrator stated he initiated the placement of a new IP who was the ADON, although the ADON was not certified. Administrator stated that DON2 from their sister facility assisted ADON during the outbreak. On [DATE] at 12:00 PM, a review of an e-mail dated [DATE], Re: Liliha IP support and leadership during outbreak, Administrator responded to the ICC , Thank you for working with [name of DON2] while [name of DON] was out unexpectedly due to an acute health concern (return undetermined). As [name of DON2] is the DON at [sister facility's name], our sister facility, she cannot provide the required 20 hours of support for IP activities. She will be providing direct and remote support to our new ADON/IP [name of ADON], RN, going forward. [Name of ADON] is not IP certified. However, [name of DON2 and name of regional consultant], RN, our Regional Nurse Consultant, will also be supporting [name of ADON] in her transition and to bring this outbreak to a speedy conclusion. Review of the facility's job description for Infection Preventionist documented the position purpose, Develops, implements, and maintains a facility-wide infection prevention and control program. Duties and responsibilities in the job description include but is not limited to: (continued on next page)

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F 0882 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Develops and implements an ongoing infection prevention and control program to prevent, recognize, and control the onset and spread of infections in order to provide a safe, sanitary, and comfortable enviroment. Establish facility-wide systems for prevention, identification, reporting, investigation, and control of infections and communicable disease of residents, staff, and visitors. Develops and implements written policies and procedures in accordance with current standards of practice and recognized guidelines for infection prevent and control .Leads the facility's Infection and Prevention Control Committee. Develops actions plans to address opportunities for improvement .Reviews and/or revises the facility's infections prevention and control program, its standards, policies, and procedures annually and as needed for changes to the facility assessment to ensure they are effective and in accordance with current standards of practice for preventing and controlling infections. Provides educations related to infection preventions and control principles, policies, and procedures to staff, residents, and families .Ensure public health is notified of reportable diseases .maintains documentation of infection prevention and control program activities.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43414 Based on record review and interview with staff member the facility failed to offer updated influenza and pneumococcal immunizations to four of seven residents (Resident (R) 24, R11, R35, and R27) sampled for immunizations. Findings Include: On 11/15/22, upon review of the facility's Electronic Health Record (EHR) for immunizations; 1) R24, a [AGE] year old male, was admitted to the facility on [DATE]. Review of R24's record documented his last influenza immunization on 09/23/21 and no documentation for pneumococcal immunization. R24's record did not include if the facility offered, if the resident or resident representative refused, or did not receive the annual influenza or the pneumococcal immunizations due to medical contradictions. 2) R11, a [AGE] year old male, was admitted to the facility on [DATE]. Review of R11 's record found no documentation for influenza and pneumococcal immunizations. R11's record did not include if the facility offered, if the resident or resident representative refused, or did not receive the annual influenza or the pneumococcal immunizations due to medical contradictions. 3) R35, a [AGE] year old female, was admitted to the facility on [DATE]. Review of R35's record documented her last influenza immunization on 02/22/2018 and pneumococcal immunization (PCV13-Pneumococcal conjugate, unspecified formula) was given in 2015 outside of the facility. R35's record did not include if the facility offered, if the resident or resident representative refused, or did not receive the annual influenza or an additionl pneumococcal immunization due to medical contradictions. The Center of Disease Contol Pneumococcal Vaccine Timing for Adults, dated 04/01/2022 recommends one dose of PPSV23 at least one year after PCV13 was recieved. 4) R27, a [AGE] year old female, was admitted to the facility on [DATE]. Review of R27 's record found no documentation for influenza and pneumococcal immunization. R27's record did not include if the facility offered, if the resident or resident representative refused, or did not receive the annual influenza or the pneumococcal immunizations due to medical contradictions. On 11/15/22 at 03:12 PM Director of Nursing (DON) confirmed residents R24, R11, R35, and R27 were not offered influenza and pneumococcal immunizations. DON stated the facility follows current Centers of Disease Control and Prevention (CDC) guidelines for pneumococcal immunizations, but was unable to verbalize what they were. Review of the facility's policy and procedure Pneumococcal Vaccinations policy number 6050 documents All residents are provided the opportunity and encouraged to receive pneumococcal vaccinations. The procedure includes The Infection Control Nurse and admitting nurse are responsible to research the medical record and history to determine if the pneumococcal vaccination have ever been given and to maintain file and record the vaccination date. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy and procedure Influenza Vaccinations policy number 6034 documents Residents are protected from influenza virus by receiving the vaccine annually.

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F 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Report COVID19 data to residents and families. 44942 Based on interviews and record reviews, the facility failed to inform all residents, their representatives, and families by 5:00 PM the next calendar day following the single occurrence of a single confirmed COVID-19 infection. As a result of this deficiency, residents and their representatives were not able to make informed choices about whether to continue visiting their loved ones or be able to seek more information immediately regarding COVID-19 in the facility. Findings Include: On 11/14/22 at 08:30 AM, Administrator was interviewed and stated that the facility had a COVID-19 outbreak two weeks ago and that there were still some residents coming out of isolation. FA stated that a letter of notification about the outbreak was emailed to the residents' families. On 11/14/22, a review of the facility's COVID-19 staff line listing indicated that the following staff had been tested for COVID-19 on the following dates: Certified Nursing Assistant (CNA) 1 on 10/17/22, CNA2 on 10/20/22, Licensed Professional Nurse (LPN) 1 on 10/23/22, and CNA3 on 11/04/22. All four staff had COVID-19 symptoms prior to being tested and subsequently tested positive A review of resident line listing log documented 25 residents listed as tested positive for COVID-19 from 10/21/22 to 11/04/22. Resident (R) 24 was tested for COVID-19 on 10/21/22 for symptoms of sore throat, cough, and increased phlegm and was the first resident that had tested positive for COVID-19 in the facility. A review of R24's lab results showed that R24 was tested for COVID-19 on 10/21/22 and had results positive for COVID-19 on 10/22/22 at 05:48 AM. On 11/14/22 at 10:08 AM, an interview and concurrent record review was done with Social Worker (SW). SW stated that the Outbreak Containment letter dated 10/25/22 was emailed by SW to families and resident representatives on 10/25/22. In a subsequent interview on 11/15/22 at 3:14 PM, SW stated that the nurses only called the family if their family member tested positive, otherwise the family received the Outbreak Containment letter. When asked if a letter was sent out when CNA1 tested positive on 10/17/22, SW stated that only the Outbreak Containment letter dated 10/25/22 was emailed to families. On 11/14/22 at 12:19 PM, Director of Nursing (DON) was interviewed. DON confirmed that R24 was the first resident that tested positive for COVID-19 on 10/21/22. DON stated that the outbreak started with R24 who receives dialysis services offsite. DON did not mention any staff testing positive for COVID-19 prior to R24 testing positive. DON confirmed that a letter was emailed to the families regarding the outbreak on 10/25/22. DON stated that she thought the facility was only required to send out a letter to families if the facility had three or more COVID-19 cases in the facility. DON stated that the facility did not call all the residents' family members or representatives by 5:00 PM the next calendar day when R24 tested positive on 10/21/22. On 11/14/22 at 1:50 PM, ADON was interviewed. ADON stated that she received two calls from family members stating that they were upset that no one had notified them regarding COVID-19 in the facility. (continued on next page)

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F 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of facility policy COVID-19 Reporting #6702, dated 09/01/20, stated 7. Residents, their representatives, and families are notified of the conditions inside the facility related to COVID-19: a. By 5:00 PM the next calendar day following the occurrence of either: i. A single confirmed infection of COVID-19. ii. 3 or more residents or staff with new- onset respiratory symptoms that occur within 72 hours of each other (i.e. outbreak) .b. Cumulative updates will be provided weekly by 5:00 PM the next calendar day following the subsequent occurrence of either: i. Each time a confirmed infection of COVID-19 is identified.

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Perform COVID19 testing on residents and staff. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44942 Based on interviews and record review, the facility failed to conduct testing in a manner that is consistent with current standards of practice for COVID-19 tests. As a result of this deficiency, 4 staff and 25 residents tested positive for COVID-19. One Resident (R)10 with a positive COVID-19 test result expired. Findings Include: On [DATE] at 08:30 AM, Facility Administrator (FA) was interviewed and stated that the facility had a COVID-19 outbreak two weeks ago and that there were still some residents coming out of isolation. On [DATE], a review of the facility's COVID-19 staff line list and resident line list indicated four staff members and 25 residents (from [DATE] to [DATE]) tested positive for COVID-19. The following staff tested positive for COVID-19, Certified Nursing Assistant (CNA) 1 on [DATE], CNA2 on [DATE], Licensed Professional Nurse (LPN) 1 on [DATE], and CNA3 on [DATE]. All four staff had COVID-19 symptoms prior to being tested and subsequently tested positive. Resident (R) 24 was tested for COVID-19 on [DATE] for symptoms of sore throat, cough, and increased phlegm and was the 1st resident that had tested positive for COVID-19 in the facility. A review of R24's lab results showed that R24 was tested for COVID-19 on [DATE] and had results positive for COVID-19 on [DATE] at 05:48 AM. On [DATE] at 12:19 PM, Director of Nursing (DON) and DON2 (DON of facility's sister facility) was interviewed. DON confirmed that R24 was the first resident that tested positive for COVID-19 on [DATE]. DON stated that the outbreak started with R24 who receives dialysis services offsite. DON did not mention any information about staff testing positive before R24 tested positive. DON stated that they isolated R24 and tested his roommate who was also positive. DON stated that she was not at the facility during the first week of the outbreak due to attending a conference and then was on medical leave afterwards. Due to DON not available during the outbreak, DON2 stated that she was asked to come to the facility to assist with the outbreak. DON2 recommended the facility to test all the residents and staff. DON2 stated that the outbreak had started with three staff testing positive for COVID-19. DON2 confirmed four staff members and 25 residents tested positive for COVID-19. And one resident (R10), continued to test positive for COVID-19, deceased on [DATE]. On [DATE] at 1:00 PM, DON2 was interviewed. DON2 stated that she had previously worked as the facility's IP, but then transferred to work as the DON at a sister facility in [DATE]. DON2 stated that she had been called by Administrator on [DATE] to assist with the outbreak at this facility. DON2 reported that when she came to the facility on [DATE], only positive COVID-19 residents' and their roommates had been tested for COVID-19 and staff that had been in contact with the residents had not been tested . A total of nine residents were positive for COVID-19. She stated she then had all staff and residents tested and found 11 other residents testing positive. DON2 stated that she had to create the resident line list for the facility because they were not keeping track of the COVID-19 positive cases. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125041	A. Building B. Wing	11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liliha Healthcare Center	1814 Liliha Street Honolulu, HI 96817

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

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1:50 PM, a concurrent record review and interview was done with ADON. ADON reported that the facility tested on e resident on [DATE], one resident on [DATE], three residents on [DATE], two residents on [DATE], and two residents on [DATE] for COVID-19. ADON stated that on [DATE], she assisted with testing all staff and resident for COVID-19. ADON confirmed there was no COVID-19 line listing for staff and residents and that the facility wasn't sure if there was mass testing prior to [DATE]. When inquired about R10, ADON reviewed R10's medical record and stated that R10 had tested positive for COVID-19 on [DATE]. ADON stated that R10 was supposed to be transferred to another facility for care, but the transfer was delayed to her contracting COVID-19. ADON stated the facility would not accept R10 until she was cleared from COVID-19. ADON stated that on [DATE], R10 was found unresponsive in her room, 911 was called, and R10 was taken to the hospital. ADON stated that R10 could not be revived. Further record review of R10 indicated that R10 was admitted to the facility on [DATE]. R10's diagnoses included chronic respiratory failure, hypertensive heart and chronic kidney disease requiring dialysis. COVID-19 Resident line listing stated that R10 tested positive for COVID-19 on [DATE] and that she had symptoms of cough, fatigue, sleeping more, and eating less. Progress note dated [DATE] at 09:30 AM documented Covid antigen swab done [DATE] still positive. Re[s]ults relayed to son at bedside. Resident currently still has slight cough per son but no other symptoms. Progress note dated [DATE] at 04:30 PM documented that at 01:40 PM, R10 resident was on ongoing oxygen support at 2 liters per minute via nasal cannula and unlabored breathing, sitting at the edge of the bed. When nurse went to room again about 10 minutes later, R10 was found still sitting at the edge of the bed but with her head down. R10 was unresponsive. 911 was called and R10 was taken to the hospital. Progress note dated [DATE] at 8:51 PM documented Follow up condition of resident at KMC-ER. Per ER nurse, resident had Cardiac Arrest, expired at 15:09. ADON informed. On [DATE] at 08:26 AM, a second interview and concurrent record review was done with the DON. When inquired about what she would do if a staff member showed signs and symptoms of COVID-19 today, DON stated that she would have the staff member sent home and tested for COVID-19. When inquired if there would be any other steps that would be done after staff member was sent home, DON remained silent and stared at surveyor. Surveyor then asked if any contact tracing would be done. DON then stated that they would find who the positive employee worked in close contact with or had any significant exposure to. When asked what would constitute a close contact or significant exposure, DON had to look in the facility's infection control binder for a few minutes to find the definition of a significant exposure. DON reviewed the staff line listing for COVID-19 and stated that she did not know who created it. DON stated that she was not sure if there was any documentation showing if there was any follow-up or contact tracing done regarding staff who had tested positive for COVID-19. On [DATE] at 11:30 AM, DON stated there was no documentation on follow-up contact tracing for staff who had tested positive for COVID-19. (continued on next page)

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	125041	A. Building B. Wing	11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liliha Healthcare Center	1814 Liliha Street Honolulu, HI 96817

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 3:00 PM, review of facility policy Coronavirus Testing #6074 revised ,d+[DATE] stated Testing of Staff and Residents with COVID-19 Symptoms or Signs: 4. Residents who have signs or symptoms of COVID-19, regardless of vaccinations status, will be tested immediately and will be placed on transmission-based precautions in accordance with CDC guidance pending test results. Once test results are obtained, the facility will take the appropriate actions based on the results .Testing of Staff and Residents in response to an outbreak: 2. Upon identification of a single new case of COIVD-19 infection in any staff or residents, testing will begin immediately.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43414 Based on record review and interview with staff member the facility failed to ensure two of seven residents (Resident (R) 11 and R27) sampled for immunizations were offered and/or received the primary series of the COVID-19 vaccine. Findings Include: On 11/15/22, upon review of the facility's Electronic Health Record (EHR) for immunizations; 1) R11, a [AGE] year old male, was admitted to the facility on [DATE]. Review of R11 's record found no documentation R11 received the primary series of the COVID-19 vaccine but received the COVID-19 booster on 09/28/22. 2) R27, a [AGE] year old female, was admitted to the facility on [DATE]. Review of R27 's record found no documentation R27 received the primary series of the COVID-19 vaccine. R27's record did not include if the facility offered, if the resident or resident representative refused, or did not receive the the primary series of COVID-19 vaccine due to medical contradictions. On 11/15/22 at 03:12 PM Director of Nursing (DON) confirmed there is no documentation that residents R11 and R27 were offered the COVID-19 vaccine. Review of the facility's policy and procedure COVID-19 Resident Vaccination reviewed/revised on 06/22, defines primary series as 2-dose series of an mRNA [Messenger RNA] COVID-19 vaccine (Pfizer-BioNTech and Moderna) or a single does of [NAME] COVID-19 vaccine, for people who are moderately to severely immunocompromised, a 3-does serious of an mRNA COVID-19 vaccine or single does of [NAME] COVID-19 vaccine. The policy and procedure documents 10. COVID-19 vaccinations will be offered to resident when supplies are available, as per CDC [Centers for Disease Control and Prevention] and and/or FDA [Food and Drug Administration] guidelines unless such immunization is medically contradicted, the individual has already been immunized during this time period, or refuse to receive the vaccine .20. The resident's medical record will include documentation of the following: .b. Each dose of the vaccine administered to the resident, or; c. If the resident did not receive the COVID-19 vaccination due to medical contradiction or refusal.