STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125048	A. Building B. Wing	03/11/2022

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43414 Based on record reviews and interviews, the facility failed to complete and maintain documentation that an alleged violation was thoroughly investigated for one out of two incidents sampled. This deficient practice has the potential to affect all residents and robs them of their right to a fair and thorough investigation of alleged abuse and neglect against them. Finding includes: R159 was admitted to the facility on [DATE] and discharged to home with hospice on 08/13/21. Review of the Event Report completed by the facility on 07/30/21, the facility reported during routine rounds on 07/28/21 at 08:00 AM, R159 was assessed to have multiple purple bruises on her buttocks and anal area. Medical Director assessed bruises and felt that they were likely trauma related as they were not over bony prominences and due to the fact that the daughter had stated yesterday that resident has difficulty pooping sometimes so she massages resident and pokes her. Daughter clarified poking to mean performing digital stimulation [involves moving the finger around in a circular motion inside the rectum to stimulate the bowel reflex]. Review of the facility's nursing progress note dated 07/28/21 .assessed resident's buttocks after CNA (certified nursing assistant) reported observed bruising when providing care. Sporadic purple/red bruising surrounding anus and dark purple bruise 0.3 cm (centimeter) by 0.5 cm on left buttocks. Family has previously reported digital stimulation. No comment by resident. Family visitation paused until further notice. On 03/10/22 requested from the facility the facility's investigation reports. At 09:48 AM received the Adult Protective Services (APS) Report Form for Vulnerable Adult Abuse submitted to APS intake unit, progress notes dated 07/27/21 and 07/29/21, and two documented witness statements dated on 07/28/21 from the registered nurse (RN) and CNA who discovered the bruises on R159's buttocks and anal area. (continued on next page)

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

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/10/22 at 11:16 AM interviewed Infection Preventionist (IP), stated she attended the care plan meeting for R159 but was not involved with the investigation for the incident, but the facility decided she would be the person to speak to it. IP clarified on 07/27/21, prior to the discovered bruising, in the care plan meeting R159's daughter .shared her mom has poor output and she massages and pokes her mom . Which raised a red flag . IP further explained on discovery of the bruising on the buttocks and anal area on 07/28/21, it was assumed the bruising was due to what the daughter had mentioned at the care plan meeting on 07/27/21. IP stated, If the daughter did not share that information, they would have to dig a little more. Inquired what day the daughter performed digital stimulation, IP reviewed R159's chart and stated she does not know. Concurrent review of the facility's Witness Statements- Investigation Supplement, confirmed statements were only given by RN and CNA who discovered the bruising on 07/28/21 at 08:00 AM, .no statements from the shift before or other shifts. During a follow-up interview with IP and Director of Nursing (DON) on 03/11/22 at 08:39 AM, IP confirmed there was no documentation of an interview with the daughter, R159 or other staff members were completed. IP concurred there was no documentation to show a thorough investigation was done. Inquired with IP how she would have investigated the incident, IP explained in previous cases where a resident had a bruise, she would have reviewed the resident's skin assessments, interview CNAs that provided care to the resident, do at least a 24 hour look back and if needed up to a week, check what visitors came in, check the environment, resident lab documents, medications, .the works for sure . Interview with Administrator on 03/11/22 at 1:03 PM regarding the completed investigation provided by the facility. Inquired with Administrator how she would have investigated the incident, Administrator stated she would have followed the facility's policy on abuse to get a thorough investigation. She would have reviewed who was working during the timeframe of the incident, interview as many witnesses or staff members that could have been involved. Admistrator further stated she would look into the reason before the report itself, specifically R159's bowel movements. Review of the facility's Comprehensive Abuse Policy and Prevention Program last updated on 03/03/21, under Investigation Procedures, The components of an internal investigation will be initiated immediately and may include: 1) an initial evaluation and interview, 2) a clinical history (if needed), 3) a physical examination (if needed), 4) a psychosocial examination (if needed), and interview with potential witnesses. 5) search of the premises 6) collecting of evidence 7) documentation .All involved persons will be identified including the victim, alleged perpetrator, witness(es) and others with any information about the incident . Cross reference to F684. The facility failed to implement the physician ordered bowel movement regimen for R159.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43414 Based on observations, record reviews, and interviews, the facility failed to review and revise the comprehensive plan of care (POC) for four residents, R159, R44, R47, and R54, out of a total of 17 residents in the sample. This deficient practice failed to effectively address the residents' status, condition, and needs, and therefore not assisting these residents attain their highest practicable physical and psychosocial well-being. This deficient practice has the potential to affect all the residents at the facility. Findings include: 1) R159 was admitted to the facility on [DATE] and discharged to home with hospice on 08/13/21. Review of the Event Report completed by the facility on 07/30/21, the facility reported during routine rounds on 07/28/21 at 08:00 AM, R159 was assessed to have multiple purple bruises on her buttocks and anal area. Medical Director assessed bruises and felt that they were likely trauma related as they were not over bony prominences and due to the fact that the daughter had stated yesterday that resident has difficulty pooping sometimes so she massages resident and pokes her. Daughter clarified poking to mean performing digital stimulation [involves moving the finger around in a circular motion inside the rectum to stimulate the bowel reflex]. On 03/11/22 at 10:30 AM, reviewed R159's physician's order dated 06/21/21. The physician ordered bowel movement regimen include, Colace 100 milligrams (mg) twice a day for constipation; senna 17.2 mg twice a day for constipation; prune juice 120 milliliters (ml) PRN (as needed) if no bowel movement in two days; Milk of Magnesia (MOM) 30 milliliters PRN if no bowel movement in three days; Dulcolax suppository 10 mg PRN if no bowel movement in three days or no results from MOM; Enema Disposable PRN if no bowel movement in four days. Review of a document provided by Infection Preventionist (IP) on 03/11/22 at 08:39 AM. The document revealed that on 06/29/21 the facility added half a cup of papaya to between meal snacks and on 07/01/21 added half a cup of papaya and prune juice daily for breakfast. Interview with IP on 03/11/22 at 12:51 PM and concurrent review of R159's daily bowel movement output log and medication administration record (MAR). After the reported incident on 07/28/21, R159 did not have a bowel movement from 08/02/21 to 08/07/21, a total of six days, R159 was not administered the PRN physician ordered bowel movement regimen. IP stated, if the bowel movement regimen was followed, R159 would have been administered MOM on the third day of no bowel movement, 08/05/21. IP confirmed the POC was not revised to address treatment for constipation after an incident that resulted in R159's daughter to perform digital stimulation due to constipation. Cross Reference to F684 Quality of Care. The facility failed to implement the physician ordered bowel movement regimen for R159. 43245 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) R44 is a [AGE] year-old male admitted to the facility on [DATE] with admitting diagnoses that include right hand contracture (a shortening and hardening of muscles, tendons, or other tissue, leading to deformity and rigidity of joints), generalized muscle weakness, dementia, depression, high blood pressure, hemiplegia (paralysis of one side of the body), and hemiparesis (muscle weakness or partial paralysis on one side of the body). On 03/08/22 at 12:27 PM, R44 was observed in the MCU DR with both hands clenched into fists. At 12:40 PM, R44 was observed feeding himself with his left hand, his right hand was still tightly clenched into a fist. On 03/10/22 at 10:45 AM, an interview was done with CNA4 in the DR. CNA4 confirmed that R44 has contractures to the fingers of his right hand, and usually keeps the hand tightly clenched into a fist. CNA4 stated that she did not recall rehab (rehabilitation services) ever working with him and was unaware of any braces, hand splints, or exercises for him. CNA4 explained that although there are no orders for it, they [the CNAs] do try to put a hand roll (towel) in his right hand, but that R44 usually throws it on the side. On 03/11/22 at 2:17 PM, an interview and concurrent record review of R44's electronic health record (EHR) was done with Occupational Therapist (OT)1 in the Rehab/Exercise Room. It was noted that from 03/04/21 to 03/31/21, R44 had received occupational therapy services. In the occupational therapy assessment done on 03/04/21, OT1 documented .[R44] presents to therapy with decreased . B [bilateral] UE [upper extremity] strength and ROM [range of motion] and decreased/inconsistent functional use of right hand. On 03/30/21, prior to discharging R44 from occupational therapy services, OT1 developed a Rehab [rehabilitation] In-Service Record and Home Exercise Program which included a review of the services provided, patient-centered reminders and interventions to apply to maintain and promote ROM, and instructions with illustrations of specific exercises to continue. OT1 used this document to instruct MCU staff, both RNs and CNAs, on her recommendations. When asked, OT1 stated she was never trained on how to access or update resident POCs, that usually that was done by nursing staff. An independent review of R44's comprehensive POC found no mention of OT1's recommendations or interventions regarding his right-hand contractures. 42871 3) On 03/08/22 at 09:18 AM, an initial observation of R47 was done. R47 was sitting up in her wheelchair watching television in the activity room. Her left foot was visible underneath her blanket. It was swollen. Both of her legs were close to the ground. On 03/08/22 at 12:05 PM, R47 was sitting up in her wheelchair in the activity room watching television and eating her lunch. Both of her legs were close to the ground. On 03/08/22 at 12:30 PM, R47 was sitting up in her wheelchair, her legs close to the ground. She was observed to be asking RN6 to go back to her room. RN6 stated that she would need assistance back to her room and there was no staff available to help her. On 03/08/22 at 1:00 PM, observed R47 assisted back to bed by CNA4. R47 stated that she was tired and that her legs were swollen. CNA4 stated that she will notify the nurse regarding her swollen legs. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/08/22 at 1:07 PM, R47 was interviewed in her room. She stated that she formerly worked as a nurse. She also stated that her legs were swollen, but denied any pain. Her legs were not elevated on pillows. On 03/09/22 at 08:39 AM, R47 was observed to be sitting up in her wheelchair, her legs low to the ground, eating her breakfast. At 09:34 AM, Physician's Assistant (PA)2 visited R47. PA2 assessed R47's feet and stated that they were swollen. The PA2 instructed her to keep her legs elevated. On 03/10/22 at 08:11 AM, R47 was eating her breakfast in the activity room and a black splint was noted on her left lower leg. Her legs were noted to be swollen. Her legs were low to the ground. At 08:26 AM, R47 wheeled herself from the activity room to the dining room. Both of her legs were close to the ground. CNA4 assisted R47 to the restroom. At 08:40 AM, R47 was back in the activity room watching television. Both of her legs remained close to the ground. On 03/10/22 at 12:00 PM, a record review was done of R47's electronic health record (EHR). Discharge Summary from a hospital dated 12/13/21 stated that she had a left kneecap fracture that was nondisplaced, or the bone was cracked in only one place that did not change the alignment of the knee, which did not require surgery. But if her knee did become displaced, then surgical intervention would be needed. R47 is an [AGE] year old female admitted to the facility on [DATE] for dementia, fracture of left humerus (left upper arm), fracture of left patella (kneecap), difficulty in walking, muscle weakness, and fall. R47's POC, last reviewed/revised on 02/14/22, was read. The only entry regarding her left kneecap fracture was: Resident has complaints of acute pain R/T [related to] fracture of left humerus and left patella fracture. Intervention included: Left knee immobilizer to be used as ordered. There were no interventions to monitor and treat for leg swelling and possible displacement of her left kneecap. Further review of R47's EHR revealed that there was no note by the PA2 regarding the education given to R47 to keep her legs elevated for the swelling and no order to keep R47's lower extremities elevated. On 03/10/22 at 12:09 PM, the facility's policy Care Plans, Comprehensive Person Centered was reviewed. It stated, .13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. On 03/11/22 at 10:20 AM, RN6 was interviewed at the unit's nursing station. She stated that R47's legs should be elevated because they were swollen and that the RCM will revise the plan of care (POC) after she reviews the resident's health record. Cross reference to F684. R47 did not receive the appropriate care and monitoring for her leg swelling. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	44942 4) On 03/08/22 at 10:52 AM, R54 was observed sitting up in her bed in her room. R54 had skid socks on her feet and both feet were resting on a pillow. A foam boot was on the bed. R54 greeted surveyor and continued eating breakfast. On 03/08/22 at 12:59 PM, a concurrent interview and observation of R54 was done. Surveyor observed that R54 was not wearing her left boot. R54 stated that she was told by staff that she has an autoimmune disease that caused blisters on her left foot. R54 stated that wearing the foam boot will help the sores to heal. On 03/09/22 at 1:04 PM, R54 was in her bed. R54's foam boot was on top of the R54's closet. R54 stated, They put the heel boot on all the time except now. On 03/09/22 at 5:23 PM, R54's record was reviewed. R54 was admitted to the facility on [DATE] for acute kidney failure and Guillain-Barre Syndrome (disorder of the immune system where the nerves are attacked by immune cells that causes weakness and tingling in arms and legs). Quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 02/16/22, stated that her Brief Interview Mental Status (BIMS) score was 13, meaning that she is cognitively intact. She requires use of an indwelling catheter for urinary retention. R54 requires two-person physical assist for bed mobility and transfers Weekly Skin assessment dated [DATE], stated that R54 had blisters on her right and left ankle. Weekly Skin assessment dated [DATE], stated that there were no new blisters, continue treatment for left ankle blisters, and that right foot blisters had healed. Review of R54's Orders dated 02/24/22 stated, Left heel boot to be on at all times. Every Shift. Days, Evenings, Nights. R54's POC for Problem: Resident has popped blisters that are infected stated an approach dated 02/25/22, for Heel boot to be used on left foot 24/7. On 03/10/22 at 09:49 AM, surveyor observed R54 in bed with heel boot on left foot. Surveyor observed Registered Nurse (RN)2 and Resident Care Manager (RCM) perform dressing change to left foot. The blister to the left foot had no drainage and appeared to be healing. RN2 and RCM put R54's heel boot back on her left foot and propped her feet on a pillow. On 03/10/22 at 2:41 PM, a concurrent interview and record review was done with RCM. RCM reviewed R54's order and POC for R54's heel boot to be applied continuously on the left foot. RCM stated that the order and POC were incorrect and were ordered by the facility's former physician. RCM stated that R54 can take off her heel boot off for rest periods and to check skin circulation. RCM stated that their wound Physician Assistant (PA)1 had discussed with staff that the heel boot was used to aid in healing the blisters but was not required to be worn at all times. RCM stated that she will update R54's POC and orders. RCM further reviewed Wound Care SNF Consult Service Progress Note for 02/15/22 and 03/08/22, and confirmed the PA1 did not recommend to use heel boots continuously for R54.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43414 Based on observations, record reviews and interviews, the facility failed to provide resident centered needed care and services for three residents, R159, R20, and R47, out of a total of 17 sampled residents. The facility did not follow the physician ordered bowel regimen for R159 and R20, which resulted in a family member performing digital stimulation on R159. R159 and R20 potentially suffered discomfort and fecal impaction. R47 did not receive the appropriate care for her swollen legs and monitoring of her left kneecap for possible displacement. These deficient practices could potentially affect all residents in the facility. Findings include: 1) R159 was admitted to the facility on [DATE] and discharged to home with hospice on 08/13/21. Residents' primary language is Korean. Diagnosis include but not limited to, posterior reversible encephalopathy syndrome, unspecified encephalopathy, complete atrioventricular block, hypertensive emergency, unspecified combined systolic (congestive) and diastolic (congestive) hear failure, acute cystitis without hematuria, functional quadriplegia, dysphagia, cramp and spasm, muscle weakness, and unspecified pure hypercholesterolemia. Review of the Event Report completed by the facility on 07/30/21, the facility reported during routine rounds on 07/28/21 at 08:00 AM, R159 was assessed to have multiple purple bruises on her buttocks and anal area. Medical Director assessed bruises and felt that they were likely trauma related as they were not over bony prominences and due to the fact that the daughter had stated yesterday that resident has difficulty pooping sometimes so she massages resident and pokes her. Daughter clarified poking to mean performing digital stimulation [involves moving the finger around in a circular motion inside the rectum to stimulate the bowel reflex]. On 03/10/22 at 11:16 AM interviewed Infection Preventionist (IP), IP clarified on 07/27/21, prior to the discovered bruising, in the care plan meeting R159's daughter .shared her mom has poor output and she massages and pokes her mom . Which raised a red flag . IP did not know when and how often R159's daughter performed digital stimulation at the facility. IP shared R159 did have a history of constipation and was on bowel medication. Inquired what the protocol is for a resident who is constipated, .the nurses look at the bowel regimen. Prune juice day two, then milk mag. (milk of magnesium) day three . Concurrent review of R159's daily bowel movement output log and medication administration record (MAR), prior to the reported incident on 07/28/21, R159 did not have a bowel movement from 07/09/21 to 07/13/21, a total of five days, and from 07/15/21 to 07/21/21, a total of seven days. IP confirmed R159 was not administered the PRN (as needed) physician's ordered bowel movement regimen during those dates. Inquired if the bowel protocol should have been implemented from 07/15/21 to 07/21/21, IP stated the protocol should have been implemented, .the physician should have been called and it should have been documented. Review of R159's physician's order dated 06/21/21. The physician ordered bowel regimen included Colace 100 milligrams (mg) twice a day for constipation; senna 17.2 mg twice a day for constipation; prune juice 120 milliliters (ml) PRN if no bowel movement in two days; Milk of Magnesia (MOM) 30 milliliters PRN if no bowel movement in three days; Dulcolax suppository 10 mg PRN if no bowel movement in three days or no results from MOM; Enema Disposable PRN if no bowel movement in four days. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Interview with Infection Preventionist (IP) and Director of Nursing (DON) on 03/11/22 at 08:39 AM, IP stated the facility was aware R159 was constipated. On 03/11/22 at 10:15 AM, reviewed R159's nursing progress notes, on 06/24/21 resident with no BM (bowel movement) since 6/21/21, suppository administered. On 06/27/21, Observed resident with her gesture that she wanted to move her bowel. Resident on 3 days no BM. On 06/29/21 .resident needing frequent PRN medications to help with constipation, resident shows signs of grimacing and would occasionally yelp. Talked to resident's daughter and she said resident is constipated. on 07/01/21 in the care conference summary it was noted Daughter mentioned that resident has been complaining of pain upon having a bowel movement. Dietary to add papaya and prune juice to assist. In another note dated 07/01/21, Dtr. (Doctor) concerned about BM pattern. Resident has small BM on 06/30/21 . On 07/25/21, Saline enema administered for 3 days no BM resident in distress, produced medium formed stool and resident expressed relief. On 07/29/21, Resident daughter shared in care plan meeting that she performed an attempted rectal digital dis-impaction [a large, hard mass of stool that gets stuck so badly in your colon or rectum that you can't push it] outwithout nursing staff being aware. Daughter educated that any and all needs of the residents need to be performed by nursing staff only. During a follow-up interview with IP on 03/11/22 at 12:51 PM and concurrent review of R159's daily bowel movement output log and medication administration record (MAR), after the reported incident and learning R159's daughter had performed digital stimulation, R159 did not have a bowel movement from 08/02/21 to 08/07/21, a total of 6 days, and R159 was not administered the PRN physician's ordered bowel regimen. IP stated, if the bowel regimen was followed, R159 would have been administered MOM on the third day of no bowel movement, 08/05/21. Cross reference to F610. The facility failed to complete a thorough investigation of abuse. The facility concluded the bruises around R159's buttocks and anus area were because of R159's daughter massaging and performing digital stimulation due to constipation, with no documentation of interviews with R159, the daughter, and other staff members after the bruises were discovered. Cross reference to F657. The facility failed to revise R159's plan of care (POC) to include treatment of constipation after investigating the incident. In result, R159 continued to have an episode of prolonged constipation without treatment from the physician's ordered bowel regimen. 22063 2) R20 was admitted to the facility on [DATE] diagnoses which includes, nontraumatic intracerebral hemorrhage, unspecified; hemiplegia and hemiparesis following cerebral infarction affecting right dominant side; and major depressive disorder, single episode, unspecified. On 03/08/22 at 09:30 AM a resident interview done, the resident reported having constipation, sometimes going three to four days without bowel movement. Further queried whether he is offered medication, resident responded he doesn't worry about that and then it just comes out. On 03/09/22 at 2:45 PM a record review was done which found a physician's order for R20's bowel regimen, senna plus twice a day; prune juice, 120 ml (milliliter) for no bowel movement in two days; milk of magnesia 30 ml if no bowel movement in three days; and enema if no bowel movement in four days. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of the resident's output for January 2022, notes R20 did not have bowel movement from 01/05/22 to 01/07/22 and 01/28/22 to 01/31/22. In February 2022, R20 did not have bowel movement for the following periods, 02/01/22 to 02/07/22, 02/12/22 to 02/17/22, and 02/19/22 to 02/27/22. A review of the MAR for January and February could not find documentation that the physician ordered bowel regimen prescribed was implemented. A review of the nursing progress notes found refusal of interventions that were offered on 02/19/22, 02/25/22, 02/26/22, and 02/27/22. There is no documentation R20 was offered interventions during a five day period, from 02/20/22 to 02/24/22. R20 did not have bowel movement from 03/04/22 to 03/07/22. There is no documentation in the MAR or progress notes indicating R20's bowel regimen was implemented. Interview and concurrent record review was done with Infection Preventionist (IP) on 03/11/22 at 08:54 AM. IP confirmed R20 did not have bowel movement for two days (01/05/22 to 01/07/22), however, reported prune juice would have been offered on the 01/08/22. IP confirmed R20 did not have bowel movement from 01/28/22 to 01/31/22 and there was no documentation of R20 refusing any interventions. Reviewed the output and MAR with IP for the month of February 2022. IP confirmed R20's bowel regimen was not implemented during the following time periods, 02/03/22 to 02/06/22 (four days), 02/12/22 through 02/17/22 (six days), and 02/19/22 through 02/27/22 (nine days) and 02/20/22 to 02/24/22 (five days). The IP confirmed there was no documentation in the MAR or progress notes of attempts to offer prune juice, milk of magnesia, and enema as prescribed. IP confirmed R20 had no bowel movement from 03/04/22 to 03/07/22 and there is no documentation in the MAR or progress notes that R20 was offered and/or refused bowel protocol interventions. 42871 3) On 03/08/22 at 09:18 AM, an initial observation of R47 was done. R47 was sitting up in her wheelchair watching television in the activity room. Her left foot was visible underneath her blanket. It was swollen. Both of her legs were close to the ground. On 03/08/22 at 12:05 PM, R47 was sitting up in her wheelchair in the activity room watching television and eating her lunch. Both of her legs were close to the ground. On 03/08/22 at 12:30 PM, R47 was sitting up in her wheelchair, her legs close to the ground. She was observed to be asking Registered Nurse (RN)6 to go back to her room. RN6 stated that she would need assistance back to her room and there was no staff available to help her. On 03/08/22 at 1:00 PM, observed R47 assisted back to bed by CNA4. R47 stated that she was tired and that her legs were swollen. CNA4 stated that she will notify the nurse regarding her swollen legs. On 03/08/22 at 1:07 PM, R47 was interviewed in her room. She stated that she formerly worked as a nurse. She also stated that her legs were swollen, but denied any pain. Her legs were not elevated on pillows. On 03/09/22 at 08:39 AM, R47 was observed to be sitting up in her wheelchair, her legs low to the ground, eating her breakfast. (continued on next page)

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	125048	A. Building B. Wing	03/11/2022

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	At 09:34 AM, Physician's Assistant (PA)2 visited R47. The PA assessed R47's feet and stated that they were swollen. The PA2 instructed her to keep her legs elevated. On 03/10/22 at 08:11 AM, R47 was eating her breakfast in the activity room and a black splint was noted on her left lower leg. Her legs were noted to be swollen. Her legs were low to the ground. At 08:26 AM, R47 wheeled herself from the activity room to the dining room. Both of her legs were close to the ground. CNA4 assisted R47 to the restroom. At 08:40 AM, R47 was back in the activity room watching television. Both of her legs remained close to the ground. On 03/10/22 at 12:00 PM, a record review was done of R47's electronic health record (EHR). Discharge Summary from a hospital dated 12/13/21 stated that she had a left kneecap fracture that was nondisplaced, or the bone was cracked in only one place that did not change the alignment of the knee, which did not require surgery. But if her knee did become displaced, then surgical intervention would be needed. R47 is an [AGE] year-old female admitted to the facility on [DATE] for dementia, fracture of left humerus (left upper arm), fracture of left patella (kneecap), difficulty in walking, muscle weakness, and fall. R47's POC, last reviewed/revised on 02/14/22, was read. The only entry regarding her left kneecap fracture was: Resident has complaints of acute pain R/T [related to] fracture of left humerus and left patella fracture. Intervention included: Left knee immobilizer to be used as ordered. There were no interventions to monitor and treat for leg swelling and possible displacement of her left kneecap. Further review of R47's EHR revealed that there was no note by the PA2 regarding the education given to R47 to keep her legs elevated for the swelling and no order to keep R47's lower extremities elevated. On 03/10/22 at 12:09 PM, the facility's policy Care Plans, Comprehensive Person Centered was reviewed. It stated, .13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. On 03/11/22 at 10:20 AM, RN6 was interviewed at the unit's nursing station. She stated that R47's legs should be elevated because they were swollen and that the RCM will revise the care plan after she reviews the resident's health record. Cross reference to F725. R47's request to go back to bed was not accomodated due to the insufficient number of nursing staff.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22063 Based on record review and interviews, the facility failed to prevent the development of multiple pressure ulcers (localized damage to the skin and/or underlying soft tissue usually over a bony prominence) in one resident, R48, out of a total of 17 sampled residents. The facility did not obtain the orthopedist consult which provided instruction for the removal of a boot used for R48's left ankle fracture to assess the skin on regular intervals. This deficient practice resulted in the development of avoidable multiple pressure ulcers and could potentially affect all residents. Findings include: R48 was admitted to the facility on [DATE]. Diagnoses includes but not limited to unspecified dementia without behavioral disturbance, Type 2 diabetes mellitus without complications, unspecified osteoarthritis (unspecified site), peripheral vascular disease, and age-related osteoporosis without current pathological fracture. Record review was done on 03/10/22 at 07:15 AM. A progress note documented on 09/27/21 at 07:26 AM, R48 complained of pain to her left foot and ankle. A physician order for an x-ray was obtained. The x-ray revealed a fracture of left distal tibia (ankle). R48 was seen by the orthopedist and returned to the facility with a left leg cast on 10/05/21. The nurse that accompanied R48 to the orthopedist reported R48 needs to wear the leg cast 24/7 (24 hours, seven days a week). R48's physician was notified on 10/05/21 at 12:02 PM and ordered aircast to left leg be worn 24/7 until further notice. Progress note dated 10/24/21 documents weekly skin check was performed. The assessor noted three pressure ulcers under R48's air cast to the left lower extremity. R48 was assessed with an unstageable pressure ulcer to the top of the left foot measuring 2 centimeter (cm) (length, L) by 2.8 cm (width, W) with eschar (dead tissue) covering the wound. A second unstageable pressure ulcer was identified to the ball of the left foot, measuring 2 cm (L) by 6 cm (W) and covered with yellow tissue, unable to determine the depth of injury. The third pressure ulcer was assessed as a Stage Two (superficial tissue injury) to the bottom of the second toe on the left foot, measuring 1.4 cm (L) x 1.5 cm (W) with beefy red wound bed. Assessor also noted purulent exudate on the foot and air cast. R48 reported pain to her foot. Review of skin assessments found no documentation of assessments were performed from 10/05/21 (application of boot) through 10/16/21. The skin assessment for 10/17/21 documents no new skin issues noted. Skin was warm, dry, normal color, no petechiae, normal skin turgor, and no alterations to the skin. Interview and concurrent record review were done with the Infection Preventionist (IP) and Director of Nursing (DON) on 03/11/22 at 09:19 AM. Staff members confirmed physician's order for weekly skin assessments with a start date of 07/28/20. Staff members confirmed skin assessments were not done from 10/05/21 through 10/16/21. Inquired how would nurses assess R48's skin while wearing a boot? IP responded, the order was not to remove the boot so the nurse would assess the skin that is not covered by the boot, pain, temperature changes, and areas that could contribute to a pressure ulcer. Requested to review the orthopedist consult note, the type of boot the resident was wearing, and what lead to the nurse opening the resident's boot on 10/24/21. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview, review of requested documentation, and record review were done with the Administrator, DON, and Regional Clinical Operations Specialist (RCOS) on 03/11/22 at 10:13 AM. RCOS confirmed that there was miscommunication regarding the orthopedist's instruction for R48 to wear the boot 24/7. A copy of the physician order was provided, left air cast to be worn 24/7 till further notice which was signed on 10/06/21. RCOS reported the facility was following the physician's order. The team confirmed the facility did not obtain the orthopedist report and the reports were requested on 03/10/22. The orthopedist report was provided for review on 03/11/22 at 11:28 AM. Review of the orthopedist report, dated 10/05/21 documents the following, This CAM [Controlled Ankle Movement boot is an adjustable device that limits ankle and foot movement which is comprised of a flexible liner which the foot fits into and a rigid shell supports and protects the leg] boot can be removed or repositioned as necessary to keep the patient in a position of comfort and to assess the skin on regular intervals for reassessment. The facility provided documentation of weekly skin assessment for 10/17/21 and 10/24/21. RCOS reviewed the progress notes for possible documentation of skin assessments from 10/05/21 through 10/17/21. It was confirmed weekly skin assessments were not done during this period. RCOS was unable to recall what type of boot R48 was prescribed. The DON reported due to the use of a boot, R48's skin should be checked for sensation, color, temperature and swelling. Staff members reported, R48's boot was removed on 10/24/21 due to foul-smelling odor as documented in the progress note. Cross Reference to F689. As a result of improper transferring, R48 sustained an avoidable injury, left tibia/fibula fracture to her left foot.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22063 Based on observations, record reviews and interviews, the facility failed to: 1) provide appropriate care and supervision for residents(R), R48, R42, and R45, out of 17 residents sampled, 2) provide an environment free from hazards for residents in rooms [ROOM NUMBERS] from extremely hot water temperatures, and 3) provide an environment free from hazards for residents who suffer from memory loss who could potentially be poisoned due to an incomplete assessment of R16's smoking device. These deficient practices could negatively impact all residents in the facility by causing them harm. Findings include: 1) The facility submitted a report of an injury of unknown origin to the State Agency (SA) on 09/27/2. R48 was complaining of pain to the left foot and ankle and there was noted swelling of the left ankle, extending midway down dorsal aspect of foot was observed. R48's physician ordered an x-ray of left foot and ankle. An x-ray was ordered which showed a fracture of the left distal tibia. The facility conducted an investigation to determine the cause of the injury. The facility reported CNA6 did not implement R48's plan of care (POC) for transferring. R48 requires a mechanical lift (devices to assist with transfers and movements of individuals who require support for mobility beyond the manual support provided by caregiver alone) with two person assist, CNA6 performed a stand-pivot transfer of the resident alone. CNA6 submitted resignation notice on 09/30/21. A review of the quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 08/30/21 notes for transfers (how resident moves between surfaces, including to or from: bed, chair, wheelchair, standing position) R48 is totally dependent (full staff performance) with two plus persons physical assist. R48's POC dated 09/09/20 identifies approach (intervention) for mechanical lift for all transfers. On 03/10/22 at 10:25 AM a telephone interview was conducted with CNA6. CNA6 recalled being assigned as a floater on the day of the event, they were short of staff and he was assigned to shower the residents residing in two wings, going back and forth between two nursing units. CNA6 went to shower R48 and noticed his coworkers were all busy so he transferred R48 from bed to the shower chair alone. After the shower, CNA6 stated his coworker was still busy so he transferred R48 alone from the shower chair back to bed. CNA6 reported R48 did not fall. CNA6 reported he tried to comfort the resident and massaged her foot as she said it was sore. CNA6 was asked what kind of transfer did R48 require. CNA6 responded, two man assist and use of the lift. Further asked how he transferred R48. CNA6 responded, he stood the resident up and turned her to sit in the shower chair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/10/22 at 10:58 AM an interview was conducted with the Infection Preventionist (IP) as the staff members that conducted the investigation are no longer employed at the facility. The IP reported she participated in the investigation of this incident. IP recalled R48 presented with foot pain and following an x-ray was diagnosed with left foot fracture. The facility initiated an investigation to determine how R48 got injured. Staff members were interviewed. CNA6 reported he transferred R48 without a lift, CNA6 reportedly picked her up to stand and she said oowww. IP stated CNA6 was rushing to get the showers done and was not malicious, he made a bad choice. IP reported R48's care plan indicates to transfer resident with mechanical lift with assist of two people. IP further reported two people are always used with a mechanical lift. IP recalled during the interview, CNA6 recalled during the transfer R48 said ouch. CNA6 reportedly stated he asked R48 if she was okay, R48 responded she was sore. CNA6 also reported he attempted to massage the resident's foot and she did not say ouch. The facility's investigation was completed on 09/30/21. The facility substantiated the deficient practice and implemented a corrective action plan. A Performance Improvement Plan (PIP) was developed. The identified problem was staff chose to perform a manual transfer vs. using 2-man assist mechanical lift transfer as indicated in the resident's plan of care. The goal of the PIP was for staff to transfer residents only according to care determination documented in the Resident Profile. The interventions of the PIP included the following: auditing of resident' plan of care for those residents requiring two man assist mechanical lift was included in the plan of care and Resident Profile; re-inservice of staff to ensure they know how to find transfer information in the Resident Profile; provide information regarding safe transfer for residents at the general staff meeting; and complete mechanical lift competency for CNAs. A review of the facility's PIP project found documentation the facility completed the auditing of residents' care plans on 09/29/21 to ensure residents' that required 2-man assist mechanical lift was included in the plan of care and Resident Profile. An inservice was provided for Resident Transfers and Mechanical Lift was done on 09/29/21, the facility provided documentation of inservice attendance. The facility conducted competency checks for Transferring a Resident Using A Mechanical Lift. CNA competency checks were conducted on 10/05/21 and 10/06/21. The facility provided supporting documentation of the competency checks. The facility also presented the need for safety during the general staff meeting on 10/07/21. Random audits were also conducted in September, October, November and December in conjunction with infection control (also ensuring proper sanitization of equipment). The Administrator reported results of the PIP were brought to the Quality Assurance and Performance Improvement (QAPI) meeting for review. The PIP was successfully closed during QAPI meeting on 12/29/21. Cross Reference F686. R48 developed pressure ulcers related to the use of Controlled Ankle Movement (CAM) boot to treat the left distal tibia fracture. Cross Reference F725. R48 sustained a left ankle fracture due to CNA6 performing a transfer with R48 without assistance due to short staffing. 42871 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) On 03/08/22 at 12:05 PM, R42 was observed in the activity room sitting up in a recliner eating his lunch. He was coughing forcefully, pushed the bedside table with his lunch tray on top away from him, got up from the recliner, and started walking without his walker that was placed to the side of him. CNA5 saw him from the adjacent dining room and intervened. She asked him where he was going, grabbed his walker, placed it in front of R42 and walked with him approximately 50 feet down the hallway to a recliner where he sat down. He continued to cough forcefully while walking down the hallway with CNA5. While he sat in the recliner, a bedside table was placed in front of him with a newspaper. No staff were observed to be in any of the resident's rooms or hallway. From 12:05 PM to 12:52 PM, R42 was in the line of sight of state agency (SA) and no staff were noted to have checked R42 while he sat in the recliner secluded approximately 50 feet away from other residents and staff. There was no staff in the activity room supervising three residents (R49, R41, and R47) because all three staff (CNA4, CNA5, and RN6) scheduled for the unit were assisting residents in the dining room with their lunches or helping residents to the restroom and monitoring two residents (R23 and R6) who were actively wandering. On 03/09/22 at 08:55 AM, R42 got up from the recliner in the activity room, walked without his walker into the adjacent dining room carrying a newspaper. RN6 intervened, asked him what he wanted to do and CNA4 stated that R42 needed to use the restroom and assisted him. On 03/09/22 at 3:10 PM, R42's electronic health record (EHR) was reviewed. R42 is a [AGE] year old male admitted to the facility on [DATE]. His diagnoses include dementia, anxiety, disorientation, aphasia (disorder to express language), unsteadiness on feet, history of falling, and history of transient ischemic attacks (TIAs, also known as mini-strokes) either caused by plaques narrowing the blood pathway of arteries or small blood clots in the brain. R42's John Hopkins Fall Risk Assessment Tool dated 01/19/21 was reviewed and revealed R42 as being a High Fall Risk. His plan of care (POC) with last reviewed/revised date of 02/15/22 revealed a problem for Risk for falls due to impaired mobility, dementia with impulsive behaviors with an intervention of Assist with transfers and ambulation using FWW [front wheeled walker]. A problem was also revealed for: .has history of Wandering Behavior, unable to locate his room, going into other residents (sic) rooms and laying in bed. One of the interventions for this problem was, Resident in secured memory care unit due to his daily wandering. R42's medication administration record (MAR) was reviewed. It revealed that he was on Clopidogrel tablet (medication that prevents platelets from forming blood clots) 75 milligrams (mg) to be taken at 08:00 AM and is used to treat his TIAs. There was no entry on R42's care plan to monitor for increased bleeding or to prevent accidents which may cause unwanted bleeding. A review of R42's MDS with ARD of 02/14/22 revealed for Section G Functional Status, G0300. Balance During Transitions and Walking that R42 is Not steady, only able to stabilize with staff assistance when moving from seated to standing position. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/11/22 at 10:20 AM, RN6 was interviewed in the unit's nursing station. She stated that it was difficult to supervise all residents in the unit because there are about four to five residents who need assistance with meals and the two CNAs and one RN are assisting them, in addition to helping other residents that need to use the restroom and two residents (R23 and R6) who actively wander. On 03/11/22 at 2:15 PM, an interview was done with the DON in the conference room next to the Administrator's office. She stated that a day shift float certified nursing assistant (CNA) assists with meals. Surveyor observed only three staff (two CNAs and one RN) assist during lunch on 03/08/22, for breakfast and lunch on 03/09/22 and breakfast on 03/10/22. Cross reference to F725. R42 was not adequately supervised due to lack of staff and could suffer a potential fall. 3) On 03/09/22 at 2:40 PM, screaming was heard in the dining room while surveyor made observations in the adjacent activity room. The activity aide (AA)1 rushed out of the dining room, calling out for one of the CNAs. R45 was seen gripping the dining room table of where she was slipping under from her wheelchair. There was no staff observed in the dining and activity rooms. After approximately two minutes, CNA11 and AA1 rushed into the dining room to assist R45. RN7 followed after CNA11 called to him for assistance. CNA11 was queried after the incident, and she stated she was assisting a resident in their room and CNA9 was giving a shower to another resident. She stated that she asked AA1 to keep an eye on the residents in the dining room. On 03/10/22 at 2:13 PM the Activities Director (AD) was interviewed. She stated that she was not aware of R45's near fall and stated that AA1 should have used her walkie-talkie to call CNA11 for assistance instead of leaving the residents in the dining room unattended. She further stated only AAs with CNA experience can assist residents with care, such as assisting them to the restroom. On 03/10/22 at 3:14 PM, AA1 was asked why she did not use her walkie-talkie to call CNA11 for R45's near fall and she stated that she does not like to use it and did not provide a reason, despite further prodding by SA. On 03/10/22 at 3:30 PM, R45's EHR was reviewed. R45 is an [AGE] year old female admitted on [DATE]. Her diagnoses include dementia, anxiety, restlessness, and agitation, generalized muscle weakness, and presence of an automatic (implantable) cardiac defibrillator (a device placed under the skin to provide electric shocks to the heart when irregular heart rates are detected). R45's John Hopkins Fall Risk Assessment Tool dated 12/10/21 revealed that she is a High Fall Risk. R45's POC revealed a problem for Impaired communication due to Cantonese as primary language and impaired hearing. Another problem listed was, Resident with agitated behaviors, taking antidepressants. An intervention included, .potential for bruising as resident gets restless & attempts to get out of her chair by dangling legs or sliding down from the WC [wheelchair]. Another problem was, Risk for falls due to impaired mobility related to weakness in which an intervention was to Provide music, snack or toileting when (resident) gets restless. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Cross reference to F725. R45 was not adequately supervised due to lack of staff and suffered a potential fall. 43245 4) On 03/08/22 at 09:12 AM, during a tour of the memory care unit (MCU), a unit composed of seventeen elderly residents who had all been diagnosed with dementia, the sink water was checked in room [ROOM NUMBER]. The hot water was found to feel too hot to comfortably hold your hands under, within 10 seconds of turning on the water. This room was noted to house four female residents. There was no shower in the room. On 03/11/22 at 07:15 AM, the Maintenance Supervisor (MS) was asked to round with the state agency (SA) checking water temperatures. During the tour, temperatures were taken on the MS's digital thermometer within 15 seconds of the water being turned on. The MS confirmed that the goal was for the water coming out at the faucet to be below 120 (degrees) Fahrenheit (F). In room [ROOM NUMBER] of the MCU, the water temperature read 120 F. In the dining room (DR) restroom closest to the MCU entrance, the water temperature read 121 F. In the second DR restroom (closest to the maintenance area entrance), the water temperature read 135 F. In room [ROOM NUMBER] the water temperature read 128 F. The MS reported that there were two boilers that were responsible for heating the water for the facility. When asked to see them, the SA observed that the boiler inside the maintenance room was set to 127 F, and the second boiler (located outside the MCU) was set to 140 F. According to the U.S. Consumer Product Safety Commission, Publication 5098, Avoiding Tap Water Scalds (https://www.cpsc.gov/), Most adults will suffer third-degree burns [a type of burn that destroys the skin and damages the underlying tissue, requiring hospitalization] . with a thirty second exposure to 130 degree [F] water. Even if the temperature is 120 degrees, a five minute exposure could result in third-degree burns. 44942 5) On 03/08/22 at 2:10 PM, R16 was concurrently observed and interviewed in his room. R16 sat upright in bed and moved his arms and hands to work on his laptop computer. R16 answered questions appropriately. He stated that he vapes (a form of smoking utilizing an electronic device to inhale vapor containing nicotine or flavoring that can either be manually refilled with vaping liquid or can either use a disposable pre-filled closed cartridge) in an outside area in front of the facility and keeps his vape in a bag which is stored in a cabinet in his room. On 03/09/22 at 08:56 AM, R16's record was reviewed. R16 was admitted to the facility on [DATE]. Quarterly MDS with an ARD of 01/3/22, stated R16's Brief Interview for Mental Status (BIMS) score of 14, meaning R16 is cognitively intact. He has diagnoses of paraplegia (paralysis of all or part of your trunk, legs, and pelvic organs). He requires two-person assist with bed mobility transfers and uses an electric wheelchair to move around the facility. R16's Smoking Risk Observation Report dated 01/08/22 stated, Other - Vapes as R16's smoking materials and that R16 was a safe smoker. Review of R16's POC for smoking stated an intervention dated 03/26/2021 that Making sure resident is safe with vaping or smoking. No documentation was found regarding R16's type of vape or where R16's vape is stored. (continued on next page)

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	125048	A. Building B. Wing	03/11/2022

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/10/22 at 12:10 PM, R16 was interviewed in the first-floor dining area. R16 stated that his vape is a cartridge that contains no nicotine. A follow up interview was done with R16 in his room at 1:55 PM and he refused to show State Agency (SA) his vape when requested. On 03/10/22 at 1:34 PM, Registered Nurse (RN)2, was interviewed. RN2 stated that she was not sure what type of vape R16 has. On 03/10/22 at 2:20 PM, surveyor asked facility administrator if she knew what type of vape R16 has. The administrator stated that she was not sure what type of vape R16 has. On 03/11/22 at 07:20 AM, Administrator was interviewed. Administrator stated that the Director of Nursing (DON) spoke to R16 yesterday and that he has stated that his vape is purchased already assembled and is thrown away after it is used. Surveyor asked Administrator if the DON physically saw R16's vape. Administrator responded that she would follow-up with the DON. On 03/11/22 at 07:59 AM, a concurrent interview and record review was done with the DON. DON stated that she spoke to R16 yesterday and physically saw R16's vape. She stated that R16's vape was a cartridge and contained no nicotine. The vape can be used until it is done and can be thrown away. The vape was stored in his room in a blocked area where no one can access. DON confirmed that R16's Smoking Risk Observation Report did not document the type of vape that R16 was in possession of nor where the vape was stored. Review of facility's Smoking Policy dated 04/15/21 states E-Cigarettes, vapor devices, etc. may remain with residents if shown safe to smoke on their own. Policy does not address where e-cigarette or vapor device should be stored nor processes to follow if e-cigarette or vapor device is refillable.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44942 Based on multiple observations, interviews, and record reviews, the facility failed to provide a sufficient amount of nursing staff which includes registered nurses (RN) and certified nursing assistants (CNA) for five residents (R), R48, R42, R45, R47, and R6, out of 17 residents in the sample, to assure their safety and to maintain their highest practicable physical, mental, and psychosocial well-being. This deficient practice has the potential to affect all residents' safety and outcomes in accordance with the residents' plans of care (POC). Findings include: 1) On 03/11/22 at 09:37 AM, a concurrent interview and record review was done with Administrator and Director of Operations (DO). [NAME] Report for MDS (Minimum Data Set) 3.0 Facility Level Quality Measure Report was reviewed. DO confirmed that the facility's measures for falls, antipsychotic medications, and behavioral symptoms affecting others measured higher/comparable to the comparison group state and national averages. For example, for falls the facility observed percent was 53.8% compared to the State average of 32.6% and National average of 43.8%. For antipsychotic medications, the facility observed percent was 14.3% compared to the state average of 9.1% and National average of 14.6%. Behavioral symptoms affecting others was 21.6% for the facility, 19.6% for State average, and 19.4% for National average. When asked if the current number of staff is adequate for the facility's needs based on the [NAME] Report, DO stated that their dementia unit Hale Ho'olu, currently has 3 staff and 16 patients, which would be a staff ratio of 1:5 or 1:6. That's one RN (registered nurse) and two CNAs (certified nursing assistants) for the unit. That is enough staff for that unit. On 03/11/22 at 10:48 AM, the Infection Preventionist (IP) was interviewed. IP stated that the facility currently uses agency nurses: two licensed practical nurses (LPN) and no CNAs. 42871 2) The facility submitted a report of an injury of unknown origin to the State Agency (SA) on 09/27/22. R48 was complaining of pain to the left foot and ankle and there was noted swelling of the left ankle, extending midway down dorsal aspect (top) of foot was observed. R48's physician ordered an x-ray of left foot and ankle. An x-ray was ordered which showed a fracture of the left distal tibia (ankle). The facility conducted an investigation to determine the cause of the injury. The facility reported that CNA6 did not implement R48's care plan for transferring. R48 requires a mechanical lift (devices to assist with transfers and movements of individuals who require support for mobility beyond the manual support provided by caregiver alone) with two person assist, CNA6 performed a stand-pivot transfer of the resident alone. CNA6 submitted resignation notice on 09/30/21. A review of the quarterly MDS with an ARD of 08/30/21 notes for transfers (how resident moves between surfaces, including to or from: bed, chair, wheelchair, standing position) R48 is totally dependent (full staff performance) with two plus persons physical assist. R48's POC dated 09/09/20 identifies approach (intervention) for mechanical lift for all transfers. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/10/22 at 10:25 AM a telephone interview was conducted with CNA6. CNA6 recalled being assigned as a floater on the day of the event, they were short of staff and he was assigned to shower the residents residing in two wings, going back and forth between two nursing units. CNA6 went to shower R48 and noticed his coworkers were all busy so he transferred R48 from bed to the shower chair alone. After the shower, CNA6 stated his coworker was still busy so he transferred R48 alone from the shower chair back to bed. CNA6 reported R48 did not fall. CNA6 reported he tried to comfort the resident and massaged her foot as she said it was sore. CNA6 was asked what kind of transfer did R48 require. CNA6 responded, two man assist and use of the lift. Further asked how he transferred R48. CNA6 responded, he stood the resident up and turned her to sit in the shower chair. On 03/10/22 at 10:58 AM an interview was conducted with the Infection Preventionist (IP) as the staff members that conducted the investigation are no longer employed at the facility. The IP reported she participated in the investigation of this incident. IP recalled R48 presented with foot pain and following an x-ray was diagnosed with left foot fracture. The facility initiated an investigation to determine how R48 got injured. Staff members were interviewed. CNA6 reported he transferred R48 without a lift, CNA6 reportedly picked her up to stand and she said oowww. IP stated CNA6 was rushing to get the showers done and was not malicious, he made a bad choice. IP reported R48's POC indicates to transfer resident with mechanical lift with assist of two people. IP further reported two people are always used with a mechanical lift. 3) On 03/08/22 at 12:05 PM, R42 was observed in the activity room sitting up in a recliner eating his lunch. He was coughing forcefully, pushed the bedside table with his lunch tray on top away from him, got up from the recliner, and started walking without his walker that was placed to the side of him. CNA5 saw him from the adjacent dining room and intervened. She asked him where he was going, grabbed his walker, placed it in front of R42 and walked with him approximately 50 feet down the hallway to a recliner where he sat down. He continued to cough forcefully while walking down the hallway with CNA5. While he sat in the recliner, a bedside table was placed in front of him with a newspaper. No staff were observed to be in any of the resident's rooms or hallway. From 12:05 PM to 12:52 PM, R42 was in the line of sight of SA and no staff were noted to have checked R42 while he sat in the recliner secluded approximately 50 feet away from other residents and staff. There was no staff in the activity room supervising three residents (R49, R41, and R47) because all three staff (CNA4, CNA5, and RN6) scheduled for the unit were assisting residents in the dining room with their lunches or helping residents to the restroom and monitoring two residents (R6 and R23) who were actively wandering. On 03/09/22 at 08:55 AM, R42 got up from the recliner in the activity room, walked without his walker into the adjacent dining room carrying a newspaper. RN6 intervened, asked him what he wanted to do and CNA4 stated that R42 needed to use the restroom and assisted him. On 03/09/22 at 3:10 PM, R42's electronic health record (EHR) was reviewed. R42 is a 64-year -old male admitted to the facility on [DATE]. His diagnoses include dementia, anxiety, disorientation, aphasia (disorder to express language), unsteadiness on feet, history of falling, and history of transient ischemic attacks (TIAs, also known as mini-strokes) either caused by plaques narrowing the blood pathway of arteries or small blood clots in the brain. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R42's John Hopkins Fall Risk Assessment Tool dated 01/19/21 was reviewed and revealed R42 as being a High Fall Risk. His plan of care (POC) with last reviewed/revised date of 02/15/22 revealed a problem for Risk for falls due to impaired mobility, dementia with impulsive behaviors with an intervention of Assist with transfers and ambulation using FWW [front wheeled walker]. A problem was also revealed for: .has history of Wandering Behavior, unable to locate his room, going into other residents (sic) rooms and laying in bed. One of the interventions for this problem was, Resident in secured memory care unit due to his daily wandering. R42's medication administration record (MAR) was reviewed. It revealed that he was on Clopidogrel tablet (medication that prevents platelets from forming blood clots) 75 milligrams (mg) to be taken at 08:00 AM and is used to treat his TIAs. There was no entry on R42's care plan to monitor for increased bleeding or to prevent accidents which may cause unwanted bleeding. A review of R42's MDS with ARD of 02/14/22 revealed for Section G Functional Status, G0300. Balance During Transitions and Walking that R42 is Not steady, only able to stabilize with staff assistance when moving from seated to standing position. On 03/11/22 at 10:20 AM, RN6 was interviewed in the unit's nursing station. She stated that it was difficult to supervise all residents in the unit because there are about four to five residents who need assistance with meals and the two CNAs and one RN are assisting them, in addition to helping other residents that need to use the restroom and two residents (R6 and R23) who actively wander. On 03/11/22 at 2:15 PM, an interview was done with the DON in the conference room next to the Administrator's office. She stated that a day shift float certified nursing assistant (CNA) assists with meals. Surveyor observed only three staff (two CNAs and one RN) during lunch on 03/08/22 and for breakfast and lunch on 03/09/22 and during breakfast on 03/10/22. 4) On 03/09/22 at 2:40 PM, screaming was heard in the dining room while surveyor made observations in the adjacent activity room. The activity aide (AA)1 rushed out of the dining room, calling out for one of the CNAs. R45 was seen gripping the dining room table of where she was slipping under from her wheelchair. There was no staff observed in the dining and activity rooms. After approximately two minutes, CNA11 and AA1 rushed into the dining room to assist R45. RN7 followed after CNA11 called to him for assistance. CNA11 was queried after the incident, and she stated she was assisting a resident in their room and CNA9 was giving a shower to another resident. She stated that she asked AA1 to keep an eye on the residents in the dining room. On 03/10/22 at 2:13 PM the activities director (AD) was interviewed. She stated that she was not aware of R45's near fall and stated that AA1 should have used her walkie-talkie to call CNA11 for assistance instead of leaving the residents in the dining room unattended. She further stated only AAs with CNA experience can assist residents with care, such as assisting them to the restroom. On 03/10/22 at 3:14 PM, AA11 was asked why she did not use her walkie-talkie to call CNA11 for R45's near fall and she stated that she does not like to use it and did not provide a reason, despite further prodding by SA. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/10/22 at 3:30 PM, R45's EHR was reviewed. R45 is an [AGE] year-old female admitted on [DATE]. Her diagnoses include dementia, anxiety, restlessness, and agitation, generalized muscle weakness, and presence of an automatic (implantable) cardiac defibrillator (a device placed under the skin to provide electric shocks to the heart when irregular heart rates are detected). R45's John Hopkins Fall Risk Assessment Tool dated 12/10/21 revealed that she is a High Fall Risk. R45's POC revealed a problem for Impaired communication due to Cantonese as primary language and impaired hearing. Another problem listed was, Resident with agitated behaviors, taking antidepressants. An intervention included, .potential for bruising as resident gets restless & attempts to get out of her chair by dangling legs or sliding down from the WC [wheelchair]. Another problem was, Risk for falls due to impaired mobility related to weakness in which an intervention was to Provide music, snack or toileting when [resident] gets restless. 5) On 03/08/22 at 12:30 PM, R47 was sitting up in her wheelchair, her legs close to the ground. She was observed to be asking RN6 to go back to her room. RN6 stated that she would need assistance back to her room and there was no staff available to help her. On 03/08/22 at 1:00 PM, observed R47 assisted back to bed by CNA4. R47 stated that she was tired and that her legs were swollen. CNA4 stated that she will notify the nurse regarding her swollen legs. On 03/08/22 at 1:10 PM, R47 was interviewed in her room. She stated that she was a former nurse. On 03/10/22 at 12:00 PM, a record review was done of R47's electronic health record (EHR). Discharge Summary from a hospital dated 12/13/21 stated that she had a left kneecap fracture that was nondisplaced, or the bone was cracked in only one place that did not change the alignment of the knee, which did not require surgery. But if her knee did become displaced, then surgical intervention would be needed. R47 is an [AGE] year-old female admitted to the facility on [DATE] for dementia, fracture of left humerus (left upper arm), fracture of left patella (kneecap), difficulty in walking, muscle weakness, and fall. On 03/11/22 at 10:20 AM, RN6 was interviewed at the unit's nursing station. She stated that R47's legs should be elevated because they were swollen and confirmed that R47 was a retired nurse. 6) R6 is a [AGE] year-old male admitted to the facility on [DATE] for long-term care services with diagnoses that include Alzheimer's dementia, chronic kidney disease, anemia, high blood pressure, diabetes, and hyperlipidemia (elevated lipids). R6 has been housed in the facility's memory care unit (MCU) since 2020 after being identified as a resident who wanders, with a high-risk of elopement, and a risk for falls. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/08/22 at 09:20 AM, an observation was made of R6 standing outside of the MCU activity room, no door alarms were heard at the time. As soon as CNA4 noticed R6 outside, CNA4 exited the back door of the activity room and led R6 back inside. No door alarms were activated either time CNA4 opened the back door. At 09:39 AM, upon closer inspection of the back door of the activity room, it was observed that although it did have a door alarm, the sensor was not attached so that the alarm would be activated if the door was opened. An interview was done with CNA4 at that time, who immediately attached the sensor to activate the door alarm. CNA4 stated that the MCU was a secure unit, and that all exits had door alarms that should be kept activated except for the double-door fire exit in the dining room (DR). CNA4 explained that she believed R6 exited the unit through the DR, but that it should not have happened. At 09:45 AM, an inspection was done of the DR fire exit. Two heavy brown doors were observed with no alarm and no locks. When asked, CNA5 stated the fire doors were the only exit that were not locked or alarmed, but that the doors led to a gate outside that did have an alarm which remained activated at all times. At no other time throughout the day was R6 or any other resident observed outside or being taken outside. On 03/09/22 at 1:44 PM, an observation was made of the activity room's back door with the door alarm disconnected. The alarm on the side doors of the activity room were also noted to be disconnected. A tour of the outside patio area noted it was entirely paved with cement pathways and hand railings but had several wet areas following rain earlier in the day. There was an unsecured 6-foot folding ladder noted laying on the ground next to the pathway in one area, beneath a six-foot metal scaffolding. At no time throughout the day was R6 or any other resident observed outside or being taken outside. On 03/09/22 at 2:30 PM, during a review of R6's comprehensive plan of care (POC), the following interventions were noted: Staff to ensure resident accompanied during ambulation to ensure no further injury. Place in Special Memory Care Unit. Ensure all door alarms/locks are armed to reduce the risk of . [R6] leaving secure area. On 03/10/22 at 08:20 AM, R6 walked to R41, who had finished eating breakfast and sat up in his wheelchair at a table in the activity room. R6 began to handle R41's dishes on his breakfast tray. There was no staff present in the activity room to redirect him. On 03/10/22 at 3:46 PM, during medication administration with RN7, R6 could not be located inside the MCU. RN7 eventually was able to find R6 sitting alone outside at a table that was not visible from inside the MCU. On 03/11/22 at 11:09 AM, an interview was done with the Resident Care Manager (RCM) at her station. The RCM stated that MCU residents are allowed to go outside during the day, and that is why the activity room doors are not secured during the day. The RCM agreed that this is not reflected in R6's CP and that if R6 is outside, he should always be supervised due to his risk for falls. When asked for facility documentation regarding leaving doors unsecured in the MCU during the day, the RCM stated she did not think the process had been formalized but was just something that they did so that residents could enjoy being outside.