



Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>03/30/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>KUAKINI GERIATRIC CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>347 NORTH KUAKINI STREET HONOLULU, HI 96817</b>
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4 102 Continued From page 1

This Statute is not met as evidenced by:  
Based on observation, record review, staff interview and a review of the [REDACTED] agreement, the facility failed to ensure there was an initial written certification of [REDACTED] by the [REDACTED] provider for 1 of 31 residents reviewed in the Stage 2 sample.

Finding includes:

[REDACTED]

[REDACTED]

4 102

4 102 (continued)

contracted [REDACTED] provider of all [REDACTED] residents and their required documents will be reviewed by the DON and nursing management and at the quarterly Performance Improvement Committee meetings.

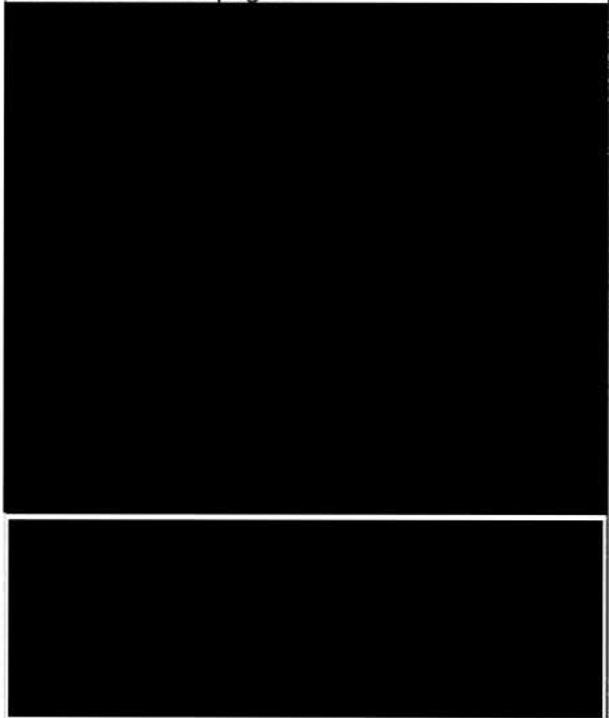
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4 102 Continued From page 2



4 102

4 113 11-94.1-27(2) Resident rights and facility practices

Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including:

(2) The right to be free of interference, coercion, discrimination, and reprisal from the facility that shall include the right to be free of

4 113

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4 113 Continued From page 3  
chemical or physical restraints not medically indicated;

This Statute is not met as evidenced by: Based on observations, staff interviews, record review, and review of facility's policy and procedures the facility failed to ensure that 1 of 3 residents in the stage 2 sample was free of physical restraints.

Findings include:

4 113

Corrective actions:

- [REDACTED] - The care plan for [REDACTED] was updated to reflect the [REDACTED] preference and choice to use the [REDACTED] occasionally. The care plan for [REDACTED] was also updated to include that the [REDACTED] should be removed from the [REDACTED] and placed in [REDACTED] when the [REDACTED] requests such a change or the [REDACTED] appears to want to [REDACTED]
- The [REDACTED] Assessment Report for [REDACTED] was updated.

Identification of other residents:

- A comprehensive review of all residents currently using a [REDACTED] was completed by the DON and nursing management to ensure that the use of [REDACTED] were appropriate and not used as [REDACTED]

Systemic changes:

- Interdisciplinary Team (IDT) members were re-educated on the Physical Restraint / Other Devices policy and the facility's commitment to being a restraint-free environment.
- Nursing staff were re-educated on the Physical Restraint / Other Devices policy and the facility's commitment to provide a restraint-free environment.
- The Long Term Care Monitoring Form was revised to include observations of residents in Geri chairs by the DON and nursing management to ensure that residents remain free from any physical restraints.

Monitoring corrective actions:

- Data from the Long Term Care Monitoring Form will be reviewed monthly by the DON and nursing management, and at the monthly Interdisciplinary Team (IDT) meetings and at the quarterly Performance Improvement Committee meetings.

03/30/15

03/30/15

04/6/15

04/22/15

04/22/15

3/31/15

04/09/15 & ongoing

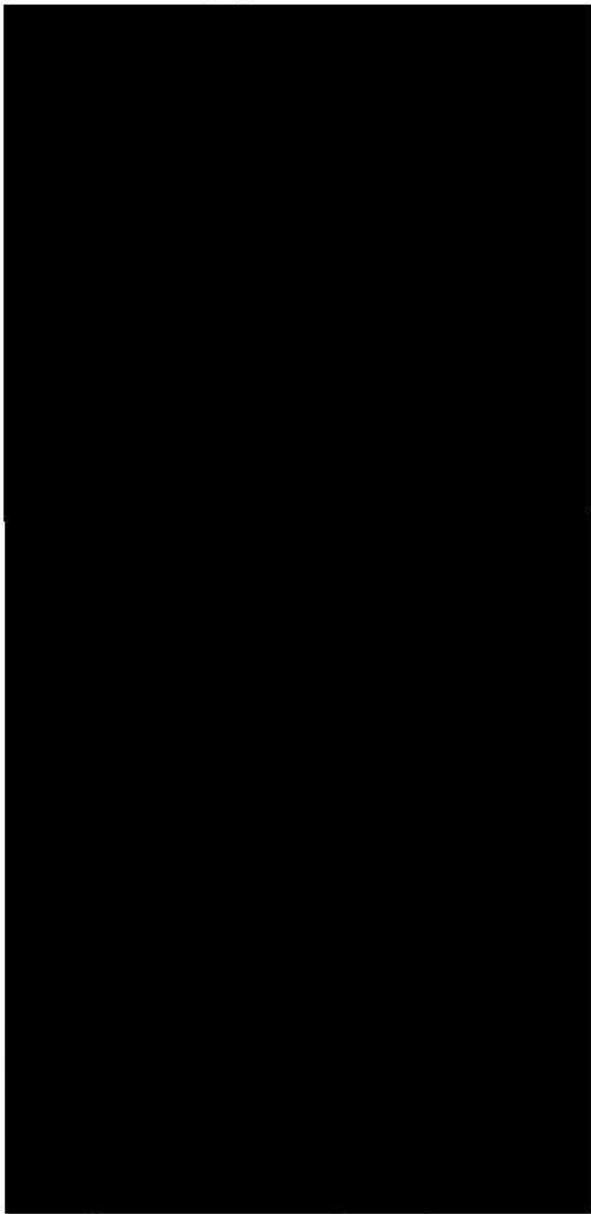
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4 113 Continued From page 4



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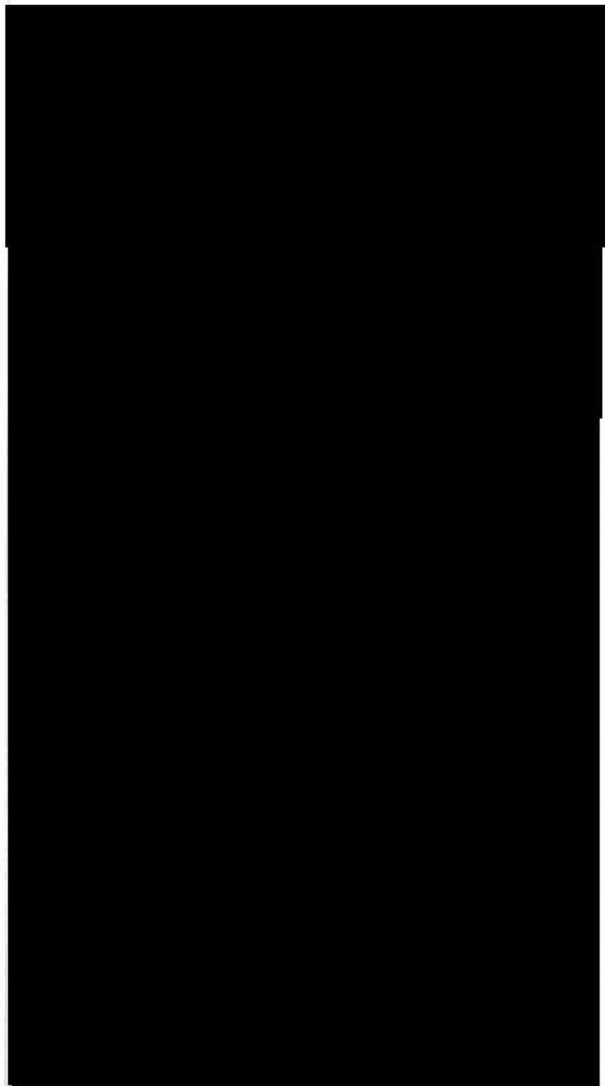
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4 113 Continued From page 5

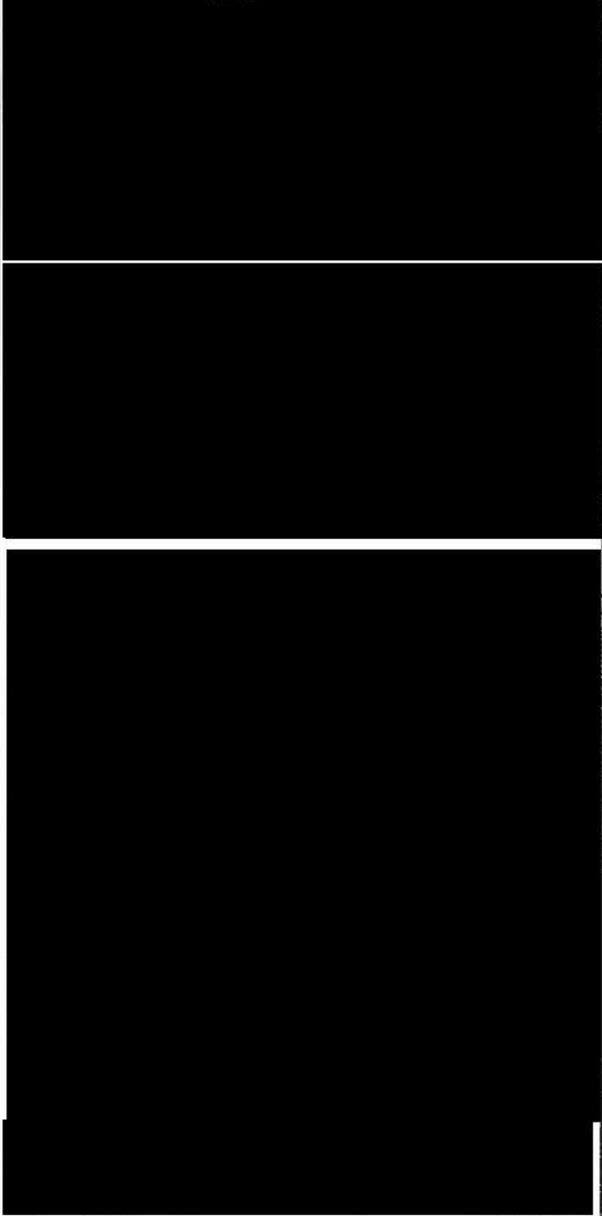


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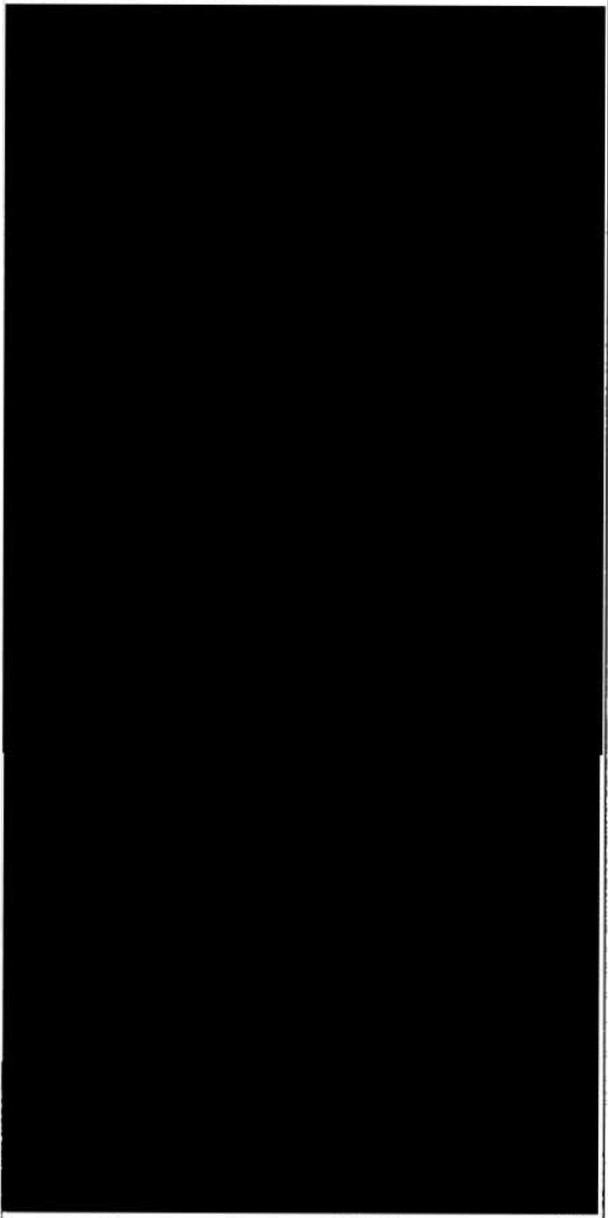
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4 113	Continued From page 6 	4 113		

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4 115	Continued From page 8	4 115	<b>4 115</b> <u>Corrective actions:</u>	
4 115	<p>11-94.1-27(4) Resident rights and facility practices</p> <p>Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including:</p> <p>(4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility;</p> <p>This Statute is not met as evidenced by: Based on observation and staff interviews the facility failed to maintain and promote an environment that enhances dignity and respect for 2 of 31 residents in the Stage 2 sample.</p> <p>Findings include:</p> <div style="background-color: black; width: 100%; height: 150px; margin-top: 10px;"></div>	4 115	<ul style="list-style-type: none"> <li>• [REDACTED] Dietary Services was notified that [REDACTED] has been discontinued from [REDACTED] and should receive meals served with regular containers and utensils to enhance the resident's dignity and respect in full recognition of resident's individuality.</li> <li>• [REDACTED] - All licensed staff caring for [REDACTED] were re-educated on the proper technique for administering medication [REDACTED] to maintain or enhance resident's dignity and respect, and the requirement for appropriate documentation in the care plan to use an alternative method of administering medication.</li> </ul> <p><u>Identification of other residents:</u></p> <ul style="list-style-type: none"> <li>• Nursing and Dietary Services completed a reconciliation between the listing of residents who require isolation precautions and the listing of residents who receive meals served with disposable containers and utensils to ensure that only residents requiring isolation precautions receive meals served with disposable containers and utensils.</li> <li>• All licensed staff will be re-educated on the proper techniques for administering medications [REDACTED] and the requirement for appropriate documentation in the care plan to use an alternative method of administering medication.</li> </ul> <p><u>Systemic changes:</u></p> <ul style="list-style-type: none"> <li>• Nursing and Dietary Services will complete a monthly reconciliation between the listing of residents who require isolation precautions and the listing of residents who receive meals served with disposable containers and utensils to ensure that only residents requiring isolation precautions receive meals served with disposable containers and utensils.</li> <li>• A checklist has been developed for use by licensed staff to track when a resident is</li> </ul>	<p>03/25/15</p> <p>03/31/15</p> <p>04/06/15</p> <p>04/29/15</p> <p>04/06/15 &amp; ongoing</p> <p>04/27/15</p>

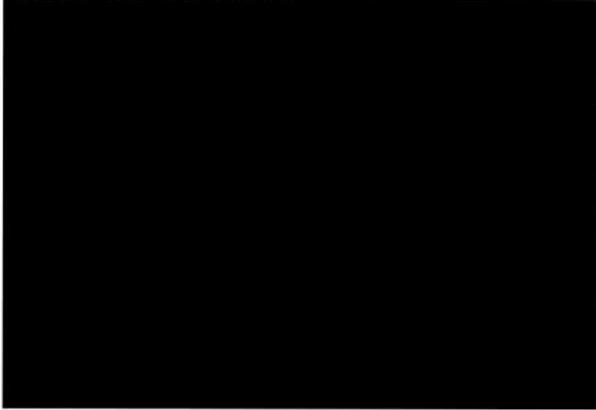
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4 115 Continued From page 9



4 115

4 115 (continued)

discontinued from isolation precautions. This checklist includes notifying Dietary Services of any change in isolation status. All licensed staff will be educated on the use of this new checklist.

- The Long Term Care Monitoring Form was revised to include meal observations by the DON and nursing management to ensure that meals served with disposable containers and utensils are used only for residents on isolation precautions.

03/31/15

- The Long Term Care Monitoring Form was revised to include medication administration observations by the DON and nursing management to ensure that medications are being administered \_\_\_\_\_ unless there is appropriate documentation in the resident's care plan indicating an alternative method of administering medication.

03/31/15

Monitoring corrective actions:

- Data from the Long Term Care Monitoring Form will be reviewed at the monthly Interdisciplinary Team (IDT) meetings and at the quarterly Performance Improvement Committee meetings.

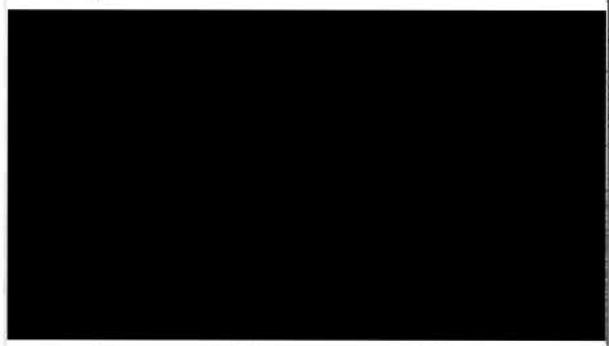
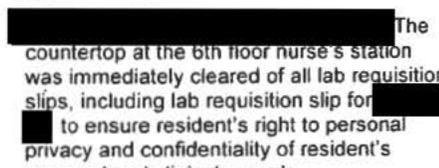
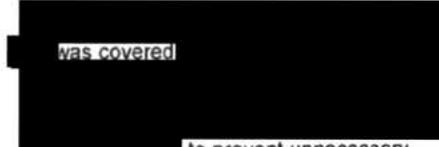
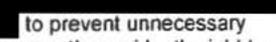
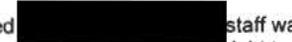
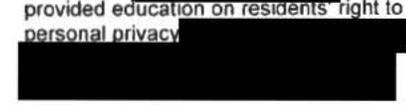
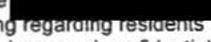
04/09/15 & ongoing



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4 125	<p>11-94.1-27(14) Resident rights and facility practices</p> <p>Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including:</p> <p>(14)The right to personal privacy and confidentiality of personal and clinical records;</p> <p>This Statute is not met as evidenced by: Based on observation and staff interviews, the facility failed to ensure residents have the right to personal privacy and confidentiality of his or her personal and clinical records for 2 of 31 residents in the Stage 2 review.</p> <p>Findings include:</p> 	4 125	<p><u>4 125</u> <u>Corrective actions:</u></p> <ul style="list-style-type: none"> <li>•  The countertop at the 6th floor nurse's station was immediately cleared of all lab requisition slips, including lab requisition slip for  to ensure resident's right to personal privacy and confidentiality of resident's personal and clinical records. 03/25/15</li> <li>•  was covered  to prevent unnecessary exposure and ensure the resident's right to personal privacy. 04/07/15</li> </ul> <p><u>Identification of other residents:</u></p> <ul style="list-style-type: none"> <li>• All SNF/ICF nurses' stations were inspected to check that residents' personal and clinical information were not visible to the public to ensure residents' right to personal privacy and confidentiality of personal and clinical records. 03/25/15</li> <li>• Contracted  staff was provided education on residents' right to personal privacy.  04/03/15</li> </ul> <p><u>Systemic changes:</u></p> <ul style="list-style-type: none"> <li>• The contracted  provider will be required to provide  staff annual training regarding residents' right to personal privacy and confidentiality of personal and clinical records. 04/20/15 &amp; ongoing</li> </ul>	

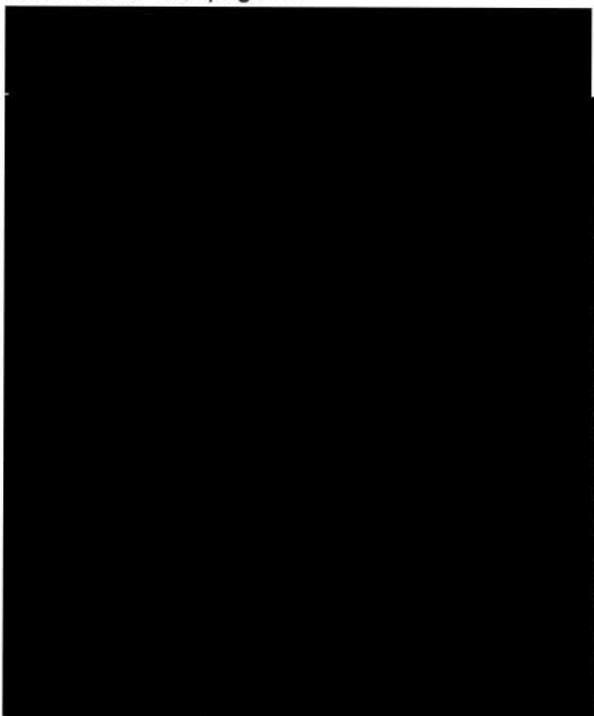
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4 125 Continued From page 11



4 125

4 125 (continued)

- The Environmental Monitoring Form was revised to include observation of all nurses' station countertops to check that residents' personal and/or clinical information are not visible to the public to ensure residents' right to personal privacy and confidentiality of personal and clinical records.
  - The Long Term Care Monitoring Form was revised to include observations by nursing management, or designee, of residents appropriate gowning/clothing to ensure residents' right to personal privacy.
- Monitoring of corrective actions:
- Data from the Environmental Monitoring Form and Long Term Care Monitoring Form will be reviewed monthly by the DON and nursing management and at the quarterly Performance Improvement Committee meetings.

03/31/15

03/31/15

04/09/15 & ongoing

4 136 11-94.1-30 Resident care

The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to:

- (1) Respiratory care including ventilator use;
- (2) Dialysis;
- (3) Skin care and prevention of skin breakdown;
- (4) Nutrition and hydration;
- (5) Fall prevention;
- (6) Use of restraints;
- (7) Communication; and
- (8) Care that addresses appropriate growth and

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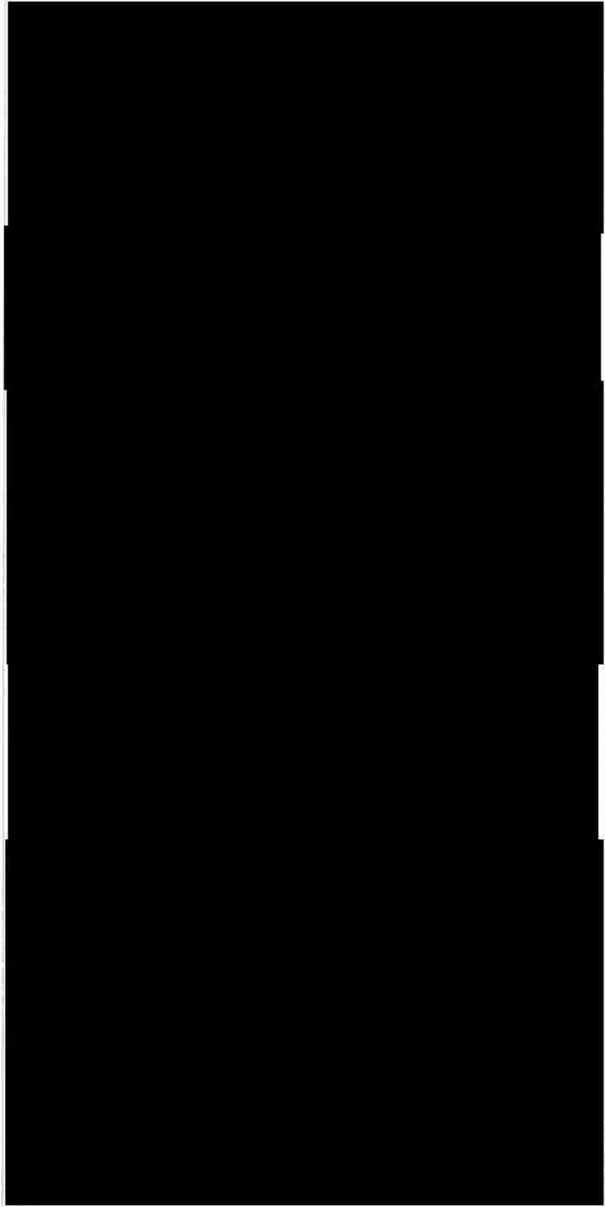
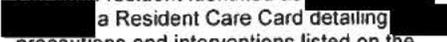
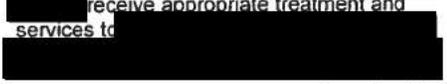
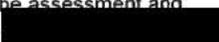
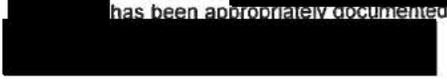
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4 136	<p>Continued From page 12</p> <p>development when the facility provides care to infants, children, and youth.</p> <p>This Statute is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to provide adequate supervision consistent with the resident needs and implement the care plan for 1 [REDACTED] of 3 residents with accidents in the stage 2 samples.</p> <p>Findings include:</p> <p>[REDACTED]</p>	4 136	<p><u>4 136</u></p> <p><u>Corrective actions:</u></p> <ul style="list-style-type: none"> <li>• [REDACTED] The care plan for [REDACTED] was updated to include that [REDACTED] should not be left unattended while out of bed. [REDACTED] resident requires adequate supervision and should not be left unattended while in the television room, solarium/dining room, and hallway [REDACTED]</li> <li>• The care plan for [REDACTED] was updated to include that [REDACTED] should be removed from [REDACTED] and placed in [REDACTED] when [REDACTED] requests such a change or [REDACTED] appears to want to [REDACTED]</li> <li>• The Licensed staff and Interdisciplinary Team (IDT) caring for [REDACTED] were educated on the revised care plan for [REDACTED]</li> <li>• [REDACTED] - The monthly summary assessment of contractures for [REDACTED] was completed by licensed staff [REDACTED] will continue to receive [REDACTED] as documented in the plan of care in order to prevent further [REDACTED]</li> <li>• Licensed staff caring for [REDACTED] were re-educated on the assessment of contractures and documenting change in [REDACTED] the plan of care.</li> </ul> <p><u>Identification of other residents:</u></p> <ul style="list-style-type: none"> <li>• A comprehensive audit of all care plans for residents [REDACTED] was completed by the DON and nursing management to ensure that all residents' care plans include adequate supervision and assistance devices [REDACTED]</li> <li>• A comprehensive review of all residents with [REDACTED] was completed by the DON and nursing management to ensure that the monthly summary assessment of [REDACTED] and [REDACTED] was appropriately documented in the residents' charts.</li> </ul>	<p>04/21/15</p> <p>04/21/15</p> <p>04/21/15</p> <p>04/03/15</p> <p>04/03/15</p> <p>04/06/15</p> <p>04/06/15</p>

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  125026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/30/2015
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NAME OF PROVIDER OR SUPPLIER  KUAKINI GERIATRIC CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 347 NORTH KUAKINI STREET HONOLULU, HI 96817
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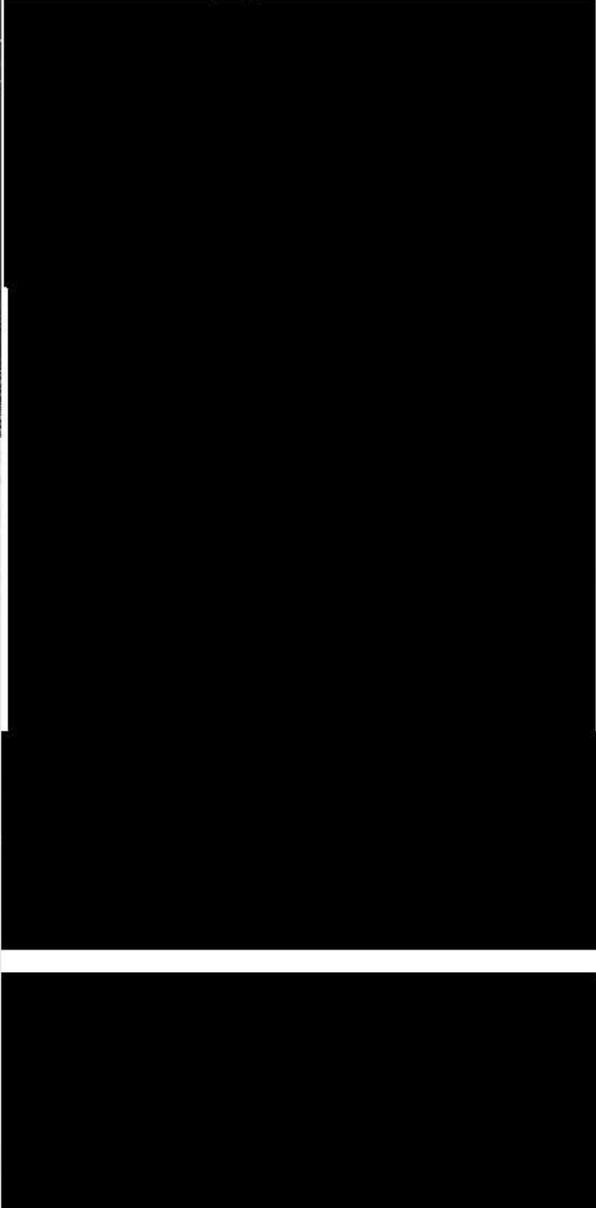
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4 136	Continued From page 13 	4 136	<p><u>4 136 (continued)</u> <u>Systemic changes:</u></p> <ul style="list-style-type: none"> <li>• For each resident identified as  a Resident Care Card detailing  precautions and interventions listed on the resident's  will be prepared and placed on the inside door of resident's closet to ensure that all staff caring for residents  are aware of the  plan for the respective residents.</li> <li>• Nursing management has implemented a Nursing Management Observation Log to document nursing management observations of staff as they provide care to the residents in accordance with residents' care plan, including residents . The Nursing Management Observation Log will be used to identify opportunities for improvement with individual staff in their performance and/or care processes.</li> <li>• All licensed staff will be re-educated on the assessment of contractures and documenting change  in the plan of care and completion of monthly summary to ensure that residents with  receive appropriate treatment and services to .</li> <li>• The Charge Nurse for each nursing unit will review the monthly summary documentation for residents with  on a quarterly basis during each resident's MDS/care plan review to ensure that the assessment and treatment of resident's  has been appropriately documented .</li> <li>• The Long Term Care Monitoring Form was revised to include chart audits of residents' monthly summary by the DON and nursing management to ensure that the assessment and treatment of residents with  has been appropriately documented .</li> </ul>	<p>05/01/15 &amp; ongoing</p> <p>04/03/15 &amp; ongoing</p> <p>04/29/15</p> <p>04/08/15 &amp; ongoing</p> <p>03/31/15</p>

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4 136	Continued From page 14 	4 136	<p><u>4 136 (continued)</u> <u>Monitoring corrective actions:</u></p> <ul style="list-style-type: none"> <li>Data from the Long Term Care Monitoring Form and the Nursing Management Observation Log will be reviewed by the DON at the monthly Interdisciplinary Team (IDT) meetings and at the quarterly Performance Improvement Committee meetings.</li> </ul>	04/09/15 & ongoing
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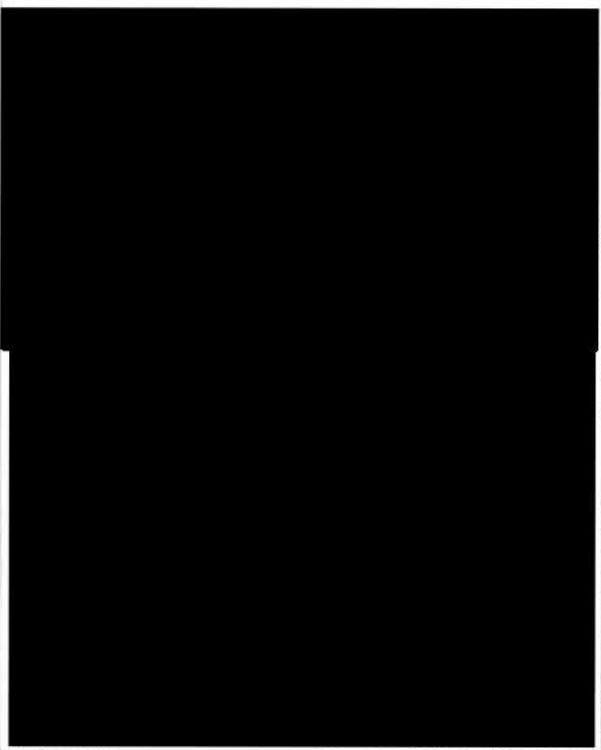
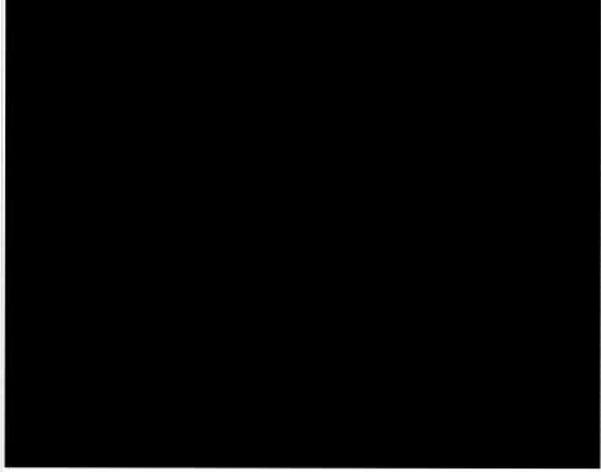
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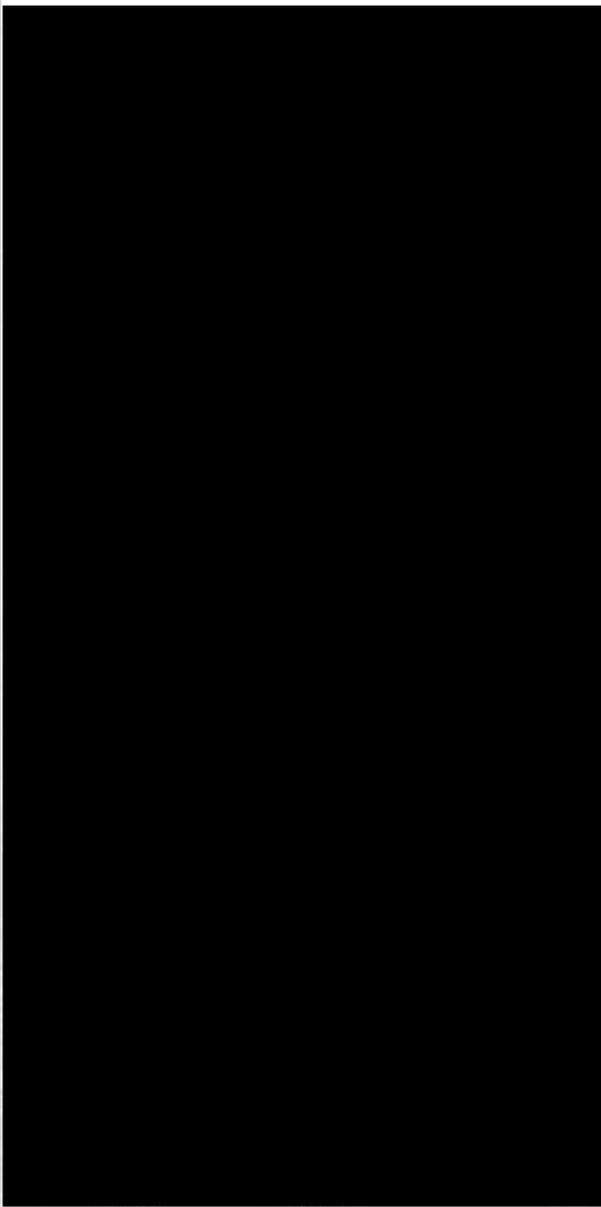
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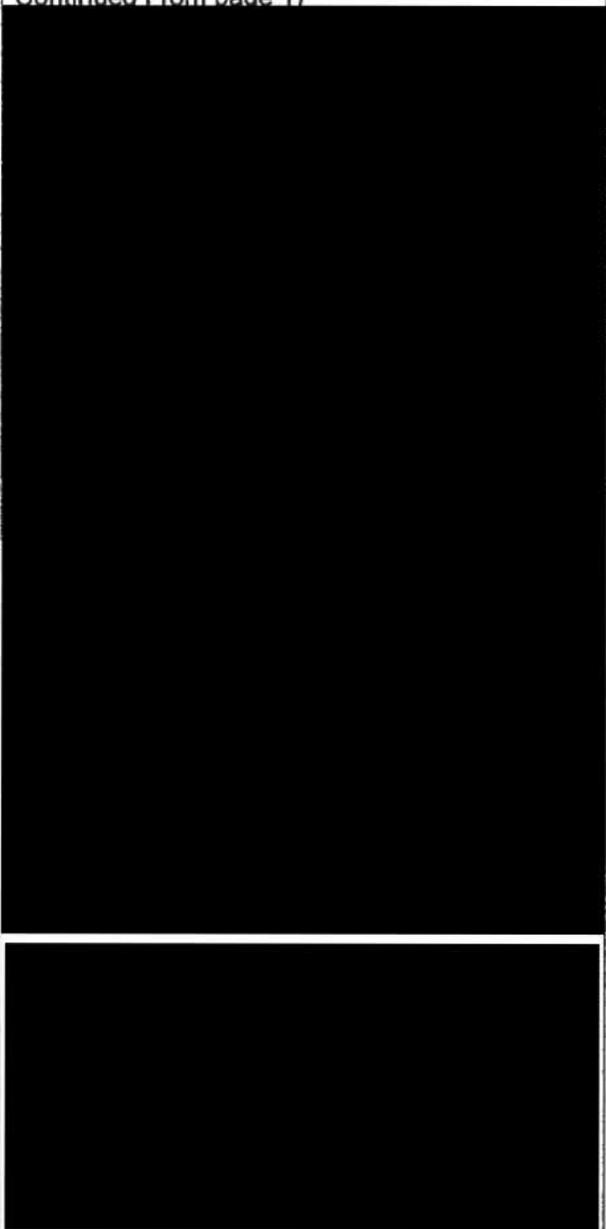
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4 136	Continued From page 16 	4 136		

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4 136	Continued From page 17 	4 136		

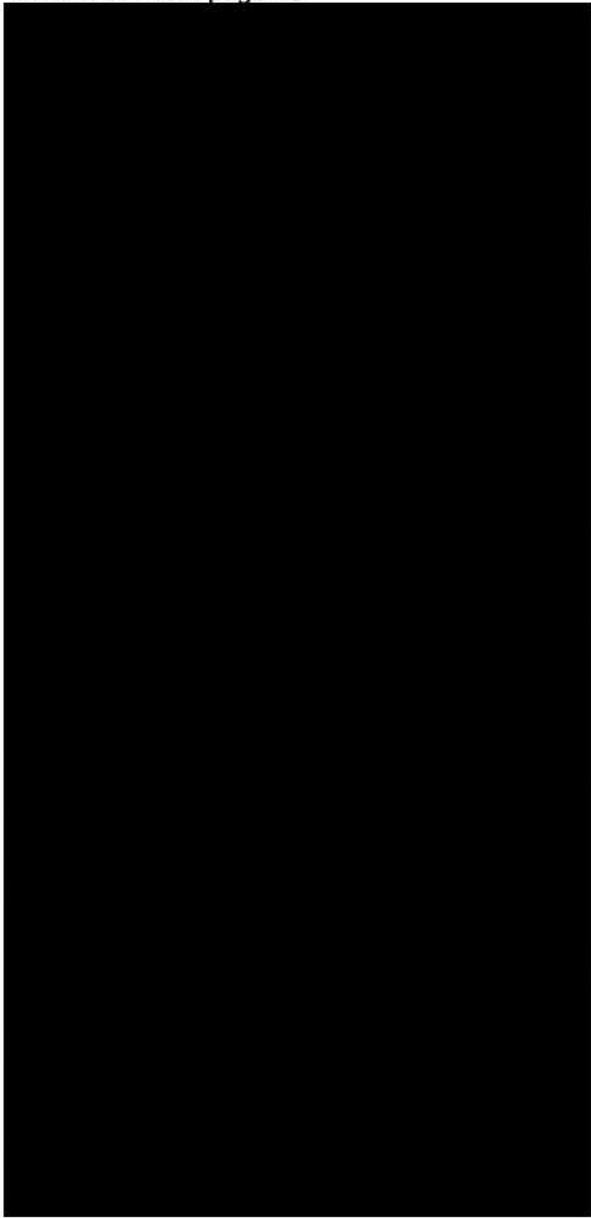
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4 136 Continued From page 18

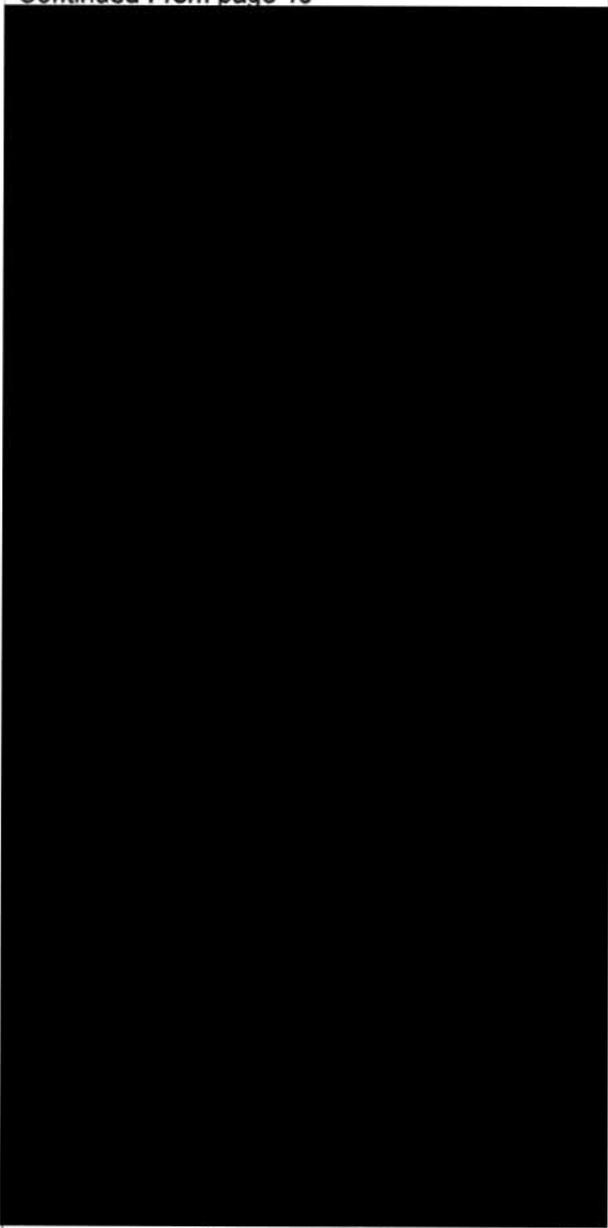


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4 136	Continued From page 19 	4 136		

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4 136	Continued From page 20 [REDACTED]	4 136		
4 162	<p>11-94.1-41(d) Storage and handling of food</p> <p>(d) In the kitchen and food preparation areas, receptacles shall be kept closed by tight-fitting covers, except in the kitchen during hours of food preparation and serving.</p> <p>This Statute is not met as evidenced by: Based on observation and staff interviews the facility failed to store food under sanitary conditions.</p> <p>Findings include:</p> <p>A second tour was conducted to the Main and HPM kitchen on the morning of 3/25/15. At 9:06 A.M. in the main kitchen, there was a metal container full of cooked kitchen without a cover on. The chef said, I was going to put a cover on but I was multitasking. An interview was conducted with [REDACTED] and said the cooked chicken should have been covered.</p> <p>[REDACTED]</p>	4 162	<p><u>4 162</u> <u>Corrective actions:</u></p> <ul style="list-style-type: none"> <li>Identified Main kitchen and HPM kitchen staff involved in survey observation were re-educated on proper covering of food items to ensure that the storage and preparation of food is maintained under sanitary conditions. 03/25/15</li> <li>Dietary staff in Main kitchen and HPM kitchen were re-educated on importance of food items being covered to ensure that the storage, preparation, and distribution of food is maintained under sanitary conditions. 03/25/15</li> </ul> <p><u>Systemic changes:</u></p> <ul style="list-style-type: none"> <li>All Dietary staff in Main kitchen and HPM kitchen will be re-educated on Dietary department policy for proper covering of unattended foods, and emphasizing that foods must be covered at all times. 04/29/15</li> <li>Food Service Supervisors will conduct daily observation rounds in all Main kitchen and HPM kitchen food preparation areas to ensure that Dietary staff are following policies for the proper storage, preparation, and distribution of food, including proper covering of food, under sanitary conditions. 04/03/15 &amp; ongoing</li> </ul> <p><u>Monitoring corrective actions:</u></p> <ul style="list-style-type: none"> <li>Food Service Supervisors will report any non-compliance to policies and procedures to Manager, Dietary Services for appropriate corrective actions. 04/03/15 &amp; ongoing</li> </ul>	
4 174	<p>11-94.1-43(b) Interdisciplinary care process</p> <p>(b) An individualized, interdisciplinary overall plan of care shall be developed to address prioritized resident needs including nursing care, social work services, medical services, rehabilitative</p>	4 174		

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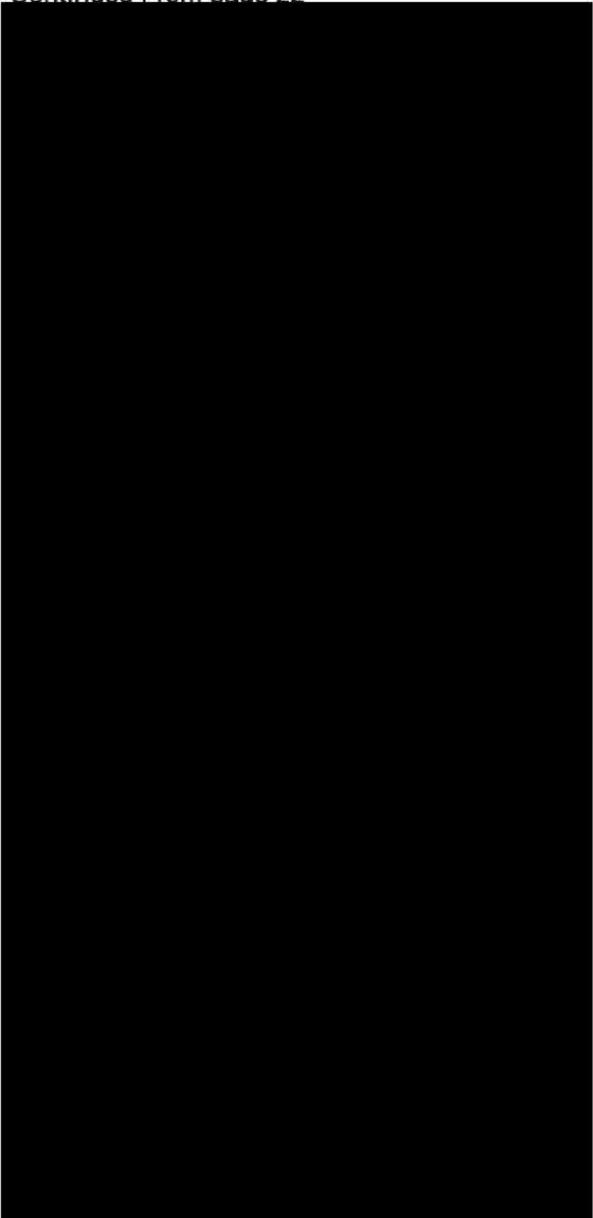
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4 174	<p>Continued From page 21</p> <p>services, restorative care, preventative care, dietary or nutritional requirements, and resident/family education.</p> <p>This Statute is not met as evidenced by: Based on observation, record review, staff interviews and review of the facility's policy/agreements, the facility failed to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 2 of 31 residents in the Stage 2 sample.</p> <p>Findings include:</p> <div style="background-color: black; width: 100%; height: 100px; margin-top: 5px;"></div> <div style="background-color: black; width: 100%; height: 100px; margin-top: 5px;"></div>	4 174	<p><u>4 174</u></p> <p><u>Corrective actions:</u></p> <ul style="list-style-type: none"> <li>• The [redacted] plan of care for skilled nursing services was obtained and placed in the chart for [redacted] and included specific approaches with measurable outcomes for the palliation and management of resident's [redacted]. 03/31/15</li> <li>• The contracted [redacted] provider providing care for [redacted] was informed of the deficiency and the contracted [redacted] provider was suspended for future admissions until corrective actions were implemented to ensure that all required documents related to [redacted] are completed appropriately by the [redacted] provider staff. 04/06/15</li> <li>• The [redacted] administration to treat the [redacted] was completed on 03/08/15. This was confirmed on 04/09/15; however, there was no documentation in the resident's plan of care. 03/31/15</li> </ul> <p><u>Identification of other residents:</u></p> <ul style="list-style-type: none"> <li>• All residents' charts for residents under [redacted] were audited to ensure that the [redacted] plan of care for skilled nursing services was completed and placed in the residents' chart, and included specific approaches with measurable outcomes for the palliation and management of residents' [redacted]. 04/09/15</li> <li>• A comprehensive review of all residents currently receiving [redacted] was completed to ensure that the resident's plan of care included use of [redacted] to meet the resident's medical needs. 04/03/15</li> </ul> <p><u>Systemic changes:</u></p> <p>The Long Term Care Monitoring Form was revised to include a chart audit of all [redacted] residents to ensure that the [redacted] plan of care for skilled nursing services was completed and includes specific approaches with measurable outcomes for the palliation and management of residents' [redacted]. 03/31/15</p>	

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4 174	Continued From page 22 	4 174	<p><b>4 174 (continued)</b></p> <ul style="list-style-type: none"> <li>The contracted  provider will complete chart audits of all  residents under their care at the scheduled 60 and 90 day certification cycle to ensure that required documents, including the  plan of care for skilled nursing services, are appropriately completed and filed in the  resident's chart. The contracted  provider audit results will be reviewed at the monthly Interdisciplinary Team (IDT) meetings to ensure that all required documents related to  care are completed appropriately by the  provider staff.</li> <li>The Long Term Care Monitoring Form was revised to include a chart audit of all residents who are receiving  to ensure that the resident's plan of care includes use of  to meet the resident's medical needs.</li> <li>The Infection Control Committee will meet weekly to review all new infections to determine whether the new infections were acquired within the facility. The Infection Control Committee will work with nursing management to ensure that a comprehensive care plan is developed for each resident receiving  that includes measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychosocial needs.</li> </ul> <p><u>Monitoring of corrective actions:</u></p> <ul style="list-style-type: none"> <li>Data from the Long Term Care Monitoring Form on the chart audits conducted by the contracted  provider of all  residents and their  plan of care for skilled nursing services and the Infection Control Committee reports will be reviewed monthly by the DON and at the quarterly Performance Improvement Committee meetings.</li> </ul>	<p>04/08/15 &amp; ongoing</p> <p>3/31/15</p> <p>04/08/15 &amp; ongoing</p> <p>04/09/15 &amp; ongoing</p>
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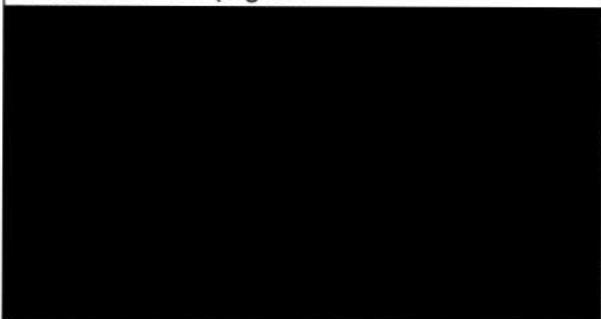
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4 174 Continued From page 23



4 174

4 185 11-94.1-46(b) Pharmaceutical services

(b) A facility shall have a current pharmacy policy manual consistent with current pharmaceutical practices developed and approved by the pharmacist, medical director/medical advisor, and director of nursing that:

(1) Includes policies and procedures, and defines the functions and responsibilities relating to pharmacy services, including the safe administration and handling of all drugs and self-administration of drugs. Policies and procedures shall include pharmacy functions and responsibilities, formulary, storage, administration, documentation, verbal and telephone orders, authorized personnel, recordkeeping, and disposal of drugs;

(2) Is reviewed at least every two years and revised as necessary to keep abreast of current developments in overall drug usage; and

(3) Has a drug recall procedure that can be readily implemented.

This Statute is not met as evidenced by:  
Based on observation, record review, and staff

4 185

4 185

Corrective actions:

- [Redacted] The Physician Order Sheet (POS) and the Medication Administration Record (MAR) was reconciled [Redacted]. The POS was updated to reflect the current medication physician order [Redacted] that reconciles with the MAR.

03/31/15

Identification of other residents:

- A comprehensive audit of all residents' medications was completed to reconcile the medication physician orders recorded on the POS with the MAR and to ensure the accurate administration of medications to the residents.

04/06/15

Systemic changes:

- The facility procedure for the monthly medication reconciliation of medication physician orders recorded on the POS with the MAR will be revised to require two (2) licensed staff to perform the medication reconciliation. 04/29/15
- The facility procedure for processing all new medication physician orders will be revised to require two (2) licensed staff to verify the medications recorded on the POS and the MAR. 04/29/15
- The facility procedure will be revised to include that the unit clerks will verify that all new medication orders have been transcribed accurately on the POS and MAR and that two (2) licensed staff has initialed the medication orders recorded on the POS and MAR. Any 04/29/15

04/29/15

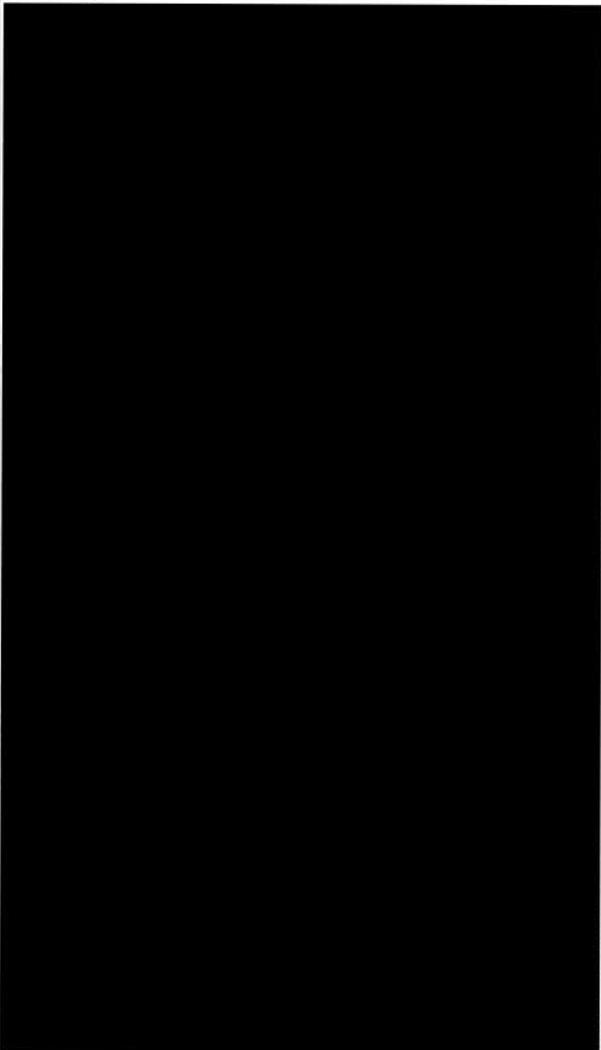
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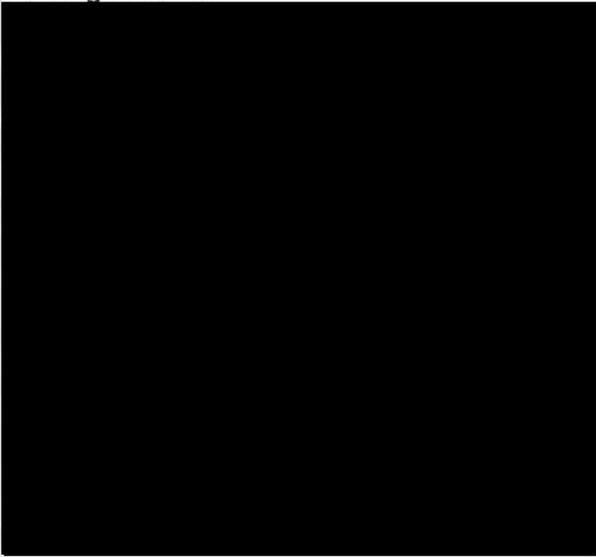
NAME OF PROVIDER OR SUPPLIER  KUAKINI GERIATRIC CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 347 NORTH KUAKINI STREET HONOLULU, HI 96817
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 185	<p>Continued From page 24</p> <p>interviews the facility failed to accurately reconcile a verbal physician's order for 1 of 31 residents in the Stage 2 sample list.</p> <p>Findings include:</p> 	4 185	<p><u>4 185 (continued)</u></p> <p>discrepancies in the recording and reconciliation of new medication orders on the POS and MAR will be reported as a medication event.</p> <ul style="list-style-type: none"> <li>The Long Term Care Monitoring Form was revised to include a review by the DON and nursing management of the monthly medication reconciliation of medication physician orders recorded on the POS and MAR, including new medication orders.</li> </ul> <p><u>Monitoring corrective actions:</u></p> <ul style="list-style-type: none"> <li>All reported medication events relating to discrepancies in the recording and reconciliation of new medication orders on the POS and MAR will be reviewed at the monthly Interdisciplinary Team (IDT) meetings and at the quarterly Performance Improvement Committee meetings.</li> <li>Data from the Long Term Care Monitoring Form will be reviewed by the DON and nursing management and at the monthly Interdisciplinary Team (IDT) meetings and at the quarterly Performance Improvement Committee meetings.</li> </ul>	<p>04/24/15</p> <p>04/29/15 &amp; ongoing</p> <p>04/29/15 &amp; ongoing</p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>03/30/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>KUAKINI GERIATRIC CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>347 NORTH KUAKINI STREET HONOLULU, HI 96817</b>
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4 185	Continued From page 25 	4 185		
4 191	<p>11-94.1-46(h) Pharmaceutical services</p> <p>(h) Prescription medication shall not be used for any resident other than the resident for whom it was issued. Stock supply items may be administered per facility protocol.</p> <p>This Statute is not met as evidenced by: Based on observation, staff and pharmacy interviews and review of the facility's policies and procedures, the facility failed to ensure that all medications are accurately labeled, are not expired and are safely secured or stored, with limited access to medications only to authorized staff.</p> <p>Findings include: </p>	4 191	<p><u>4 191</u> <u>Corrective actions:</u></p> <ul style="list-style-type: none"> <li>All excessive IV tubing and macrobore extensions in the SNF, 6<sup>th</sup> floor medication storage room were discarded. 03/31/15</li> <li>The unlabeled medications items found in the SNF, 6<sup>th</sup> floor Solarium medication refrigerator were discarded. The discarded medications were as follows:  03/31/15</li> <li>All of the medication storage rooms for the SNF and ICF were reviewed to comply with KGC's pharmacy policy on "Medication Storage in the Facility" to maintain medication storage rooms that are clean and free of clutter. 03/31/15</li> </ul> <p><u>Identification of other residents:</u></p> <ul style="list-style-type: none"> <li>All of the medication storage rooms for the SNF and ICF were checked for expired medications, excessive IV tubings, and unorganized supplies. Expired medications and excessive supplies were discarded and the supplies were organized in the storage room. 04/06/15</li> <li>All medication refrigerators were checked to ensure that there are no expired medications and that all medications are properly labeled with resident's name to ensure specific resident's use. 04/01/15</li> </ul> <p><u>Systemic changes:</u></p> <ul style="list-style-type: none"> <li>The Environmental Monitoring Form was revised to include observations of licensed staff of medication storage rooms and 03/31/15</li> </ul>	

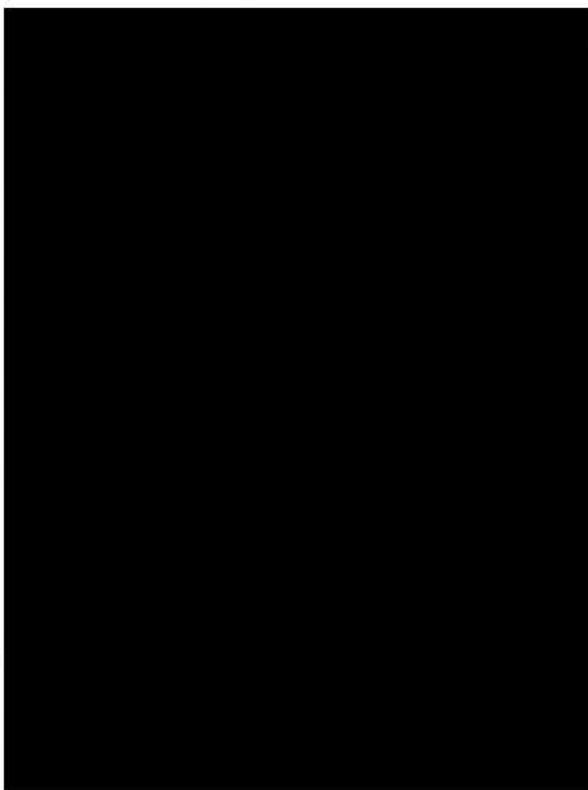
Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/30/2015</b>
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4 191 Continued From page 26



4 191

4 191 (continued)

medication refrigerators to ensure that they remain organized and free of clutter, and that there are no expired or unlabeled medications.

Monitoring corrective actions:

- Data from the Environmental Monitoring Form will be reviewed by the DON at the monthly Interdisciplinary Team (IDT) meetings and at the quarterly Performance Improvement Committee meetings.

04/09/15 & ongoing

4 194 11-94.1-46(k) Pharmaceutical services

(k) Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security.

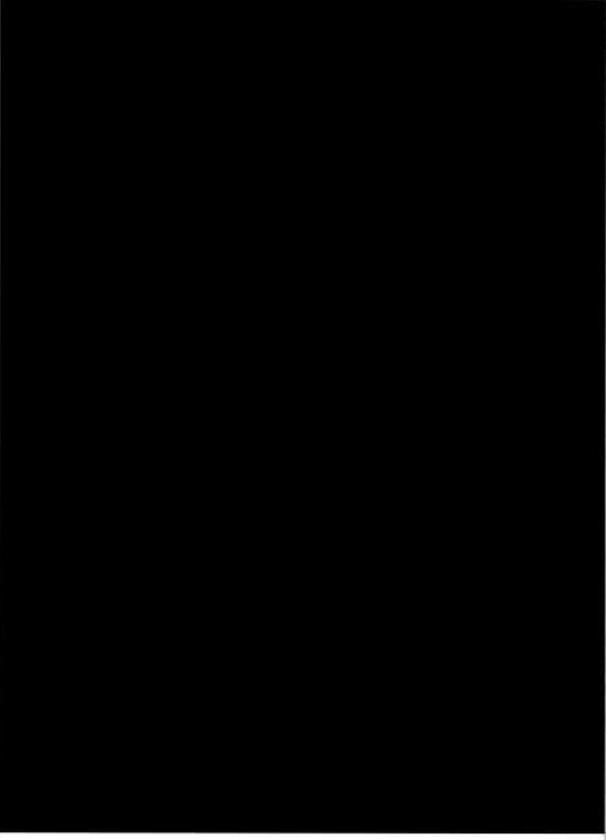
This Statute is not met as evidenced by: Based on observation, staff and pharmacy interviews and review of the facility's policies and procedures, the facility failed to ensure that all medications are accurately labeled, are not expired and are safely secured or stored, with

4 194

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4 194	<p>Continued From page 27</p> <p>limited access to medications only to authorized staff.</p> <p>Findings include:</p> 	4 194	<p><u>4 194</u></p> <p><u>Corrective actions:</u></p> <ul style="list-style-type: none"> <li>The Licensed Nurse who accepted delivery of the three (3) medication blister packs at the nurse's station and left the medications unmonitored on the counter was re-educated on the proper procedure for the acceptance and immediate storage of medications that are delivered to the nursing unit.</li> </ul> <p><u>Identification of other residents:</u></p> <ul style="list-style-type: none"> <li>All licensed staff of the SNF and ICF will be re-educated on the proper procedure for the acceptance and immediate storage of medications that are delivered to the nursing unit.</li> </ul> <p><u>Systemic changes:</u></p> <ul style="list-style-type: none"> <li>Nursing management has implemented a Nursing Management Observation Log to document nursing management observations of staff in the provision of care, including staff compliance with proper acceptance and storing of medications that are delivered to the nursing unit and compliance with KGC's pharmacy policy on "Medication Storage in the Facility". The Nursing Management Observation Log will be used to identify opportunities for improvement with individual staff in their performance and/or care processes.</li> </ul> <p><u>Monitoring corrective actions:</u></p> <ul style="list-style-type: none"> <li>Data from the Nursing Management Observation Log will be reviewed by the DON at the monthly Interdisciplinary Team (IDT) meetings and at the quarterly Performance Improvement Committee meetings.</li> </ul>	<p>03/31/15</p> <p>04/29/15</p> <p>04/03/15 &amp; ongoing</p> <p>04/09/15 &amp; ongoing</p>
4 197	<p>11-94.1-46(n) Pharmaceutical services</p> <p>(n) Discontinued and outdated prescriptions and containers with worn, illegible, or missing labels shall be disposed of according to facility policy.</p>	4 197		

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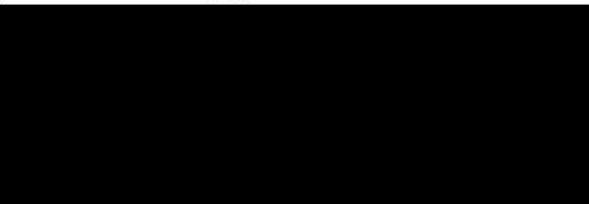
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4 197	<p>Continued From page 28</p> <p>This Statute is not met as evidenced by: Based on observation, staff and pharmacy interviews and review of the facility's policies and procedures, the facility failed to ensure that all medications are accurately labeled, are not expired and are safely secured or stored, with limited access to medications only to authorized staff.</p> <p>Findings include:</p> <div style="background-color: black; width: 100%; height: 100%; min-height: 400px;"></div>	4 197	<p><b>4 197</b></p> <p><u>Corrective actions:</u></p> <ul style="list-style-type: none"> <li>• The expired [REDACTED] found in the SNF, 6<sup>th</sup> floor medication storage room was discarded. 03/31/15</li> <li>• All excessive IV tubing and macrobore extensions in the SNF, 6<sup>th</sup> floor medication storage room were discarded. 03/31/15</li> <li>• All IV solution bags in the SNF, 6<sup>th</sup> floor medication storage room were segregated and organized. 03/31/15</li> <li>• The three (3) expired culture swabs found in the ICF, 3<sup>rd</sup> floor medication storage room were discarded. 03/31/15</li> <li>• All of the medication storage rooms for the SNF and ICF were reviewed to comply with KGC's pharmacy policy on "Medication Storage in the Facility" to maintain medication storage rooms that are clean and free of clutter. 03/31/15</li> </ul> <p><u>Identification of other residents:</u></p> <ul style="list-style-type: none"> <li>• All of the medication storage rooms for the SNF and ICF were checked for expired medications, excessive IV tubings, and unorganized supplies. Expired medications and excessive supplies were discarded and the supplies were organized in the storage room. 04/06/15</li> <li>• All medication refrigerators were checked to ensure that there are no expired medications and that all medications are properly labeled with resident's name to ensure specific resident's use. 04/01/15</li> </ul> <p><u>Systemic changes:</u></p> <ul style="list-style-type: none"> <li>• The Environmental Monitoring Form was revised to include observations of licensed staff of medication storage rooms and medication refrigerators to ensure that they remain organized and free of clutter, and that there are no expired or unlabeled medications. 03/31/15</li> </ul>	

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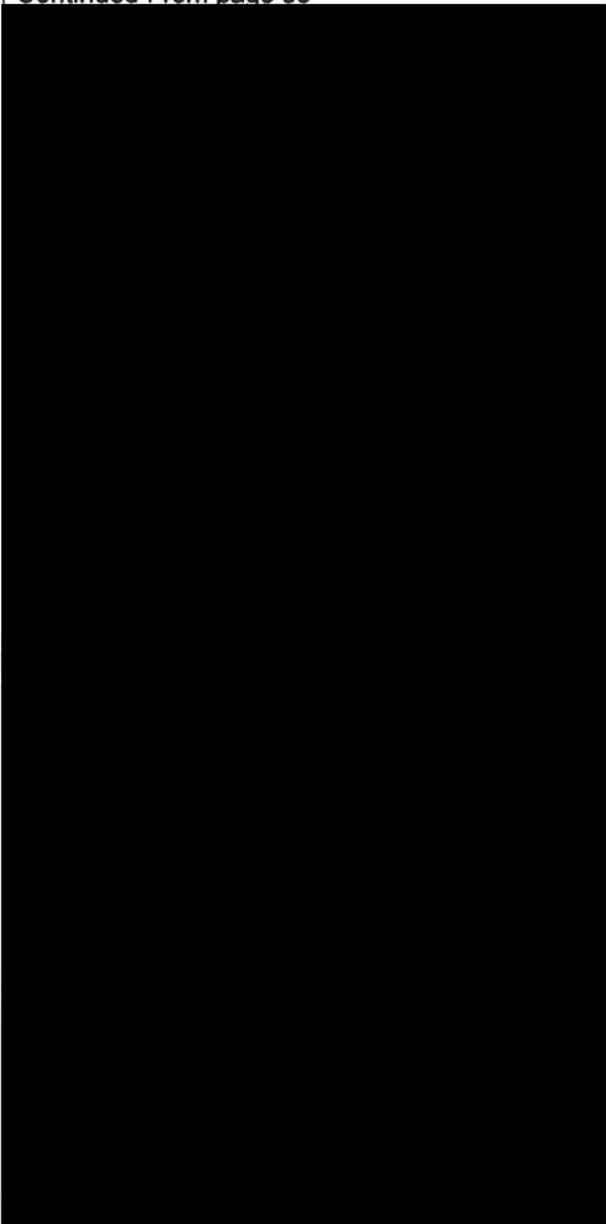
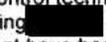
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4 197	Continued From page 29 	4 197	<b>4 197 (continued)</b> <u>Monitoring corrective actions:</u> <ul style="list-style-type: none"><li>Data from the Environmental Monitoring Form will be reviewed by the DON at the monthly Interdisciplinary Team (IDT) meetings and at the quarterly Performance Improvement Committee meetings.</li></ul>	04/09/15 & ongoing
4 203	11-94.1-53(a) Infection control  (a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste.  This Statute is not met as evidenced by: Based on observation, record review, staff interviews and review of the facility's infection control program data, the facility failed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  Findings include: 	4 203		

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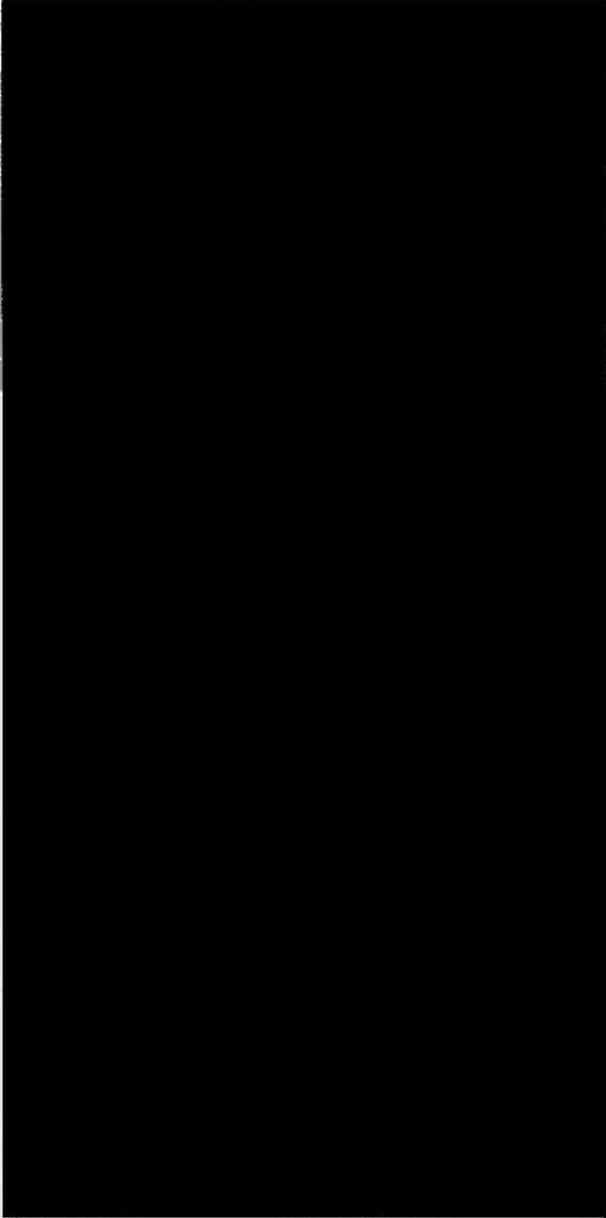
4 203	Continued From page 30 	4 203	<p><u>4 203</u> <u>Corrective actions:</u></p> <ul style="list-style-type: none"> <li>• Data analysis for the specific residents noted on the Quality Improvement Report for  for the first two quarters of the fiscal year were conducted and documented in the Infection Control Committee minutes. The analyses reviewed the (1) determination of the origin of the infections, (2) comparison of current infection control practices to past data in order to identify areas for improvement, and (3) identification of appropriate corrective measures to improve the infection control program.</li> <li>• Rehab staff  was provided additional training on (1) the proper technique for disinfecting rehab equipment utilizing the "purple top" Sani-cloths and the Virex spray, (2) required contact time for the effectiveness of the disinfectant products available to staff, and (3) location of the Rehab department's reference for infection control protocol. The procedure for the storage of the therapy ball was changed to a stand that keeps the therapy ball off rehab gym floor in order to prevent the therapy ball from touching the gym floor after being disinfected.</li> <li>• Activity Staff  was provided additional training on (1) the proper technique for disinfecting recreation activity equipment using the "purple top" Sani-cloths and the Virex spray and (2) required contact time for the effectiveness of the disinfectant products available to staff.</li> <li>•  was re-educated on the proper infection control technique for preparing and administering  including the non-use of supplies that have become unusable due to contamination.</li> <li>•  was re-educated on the proper infection control technique for hand hygiene and the need to either hand sanitize or wash hands prior to wearing gloves, and when providing care between residents.</li> <li>• All HPM kitchen staff involved in the survey</li> </ul>	<p>04/08/15</p> <p>04/06/15</p> <p>04/03/15</p> <p>04/21/15</p> <p>03/31/15</p> <p>03/25/15</p>
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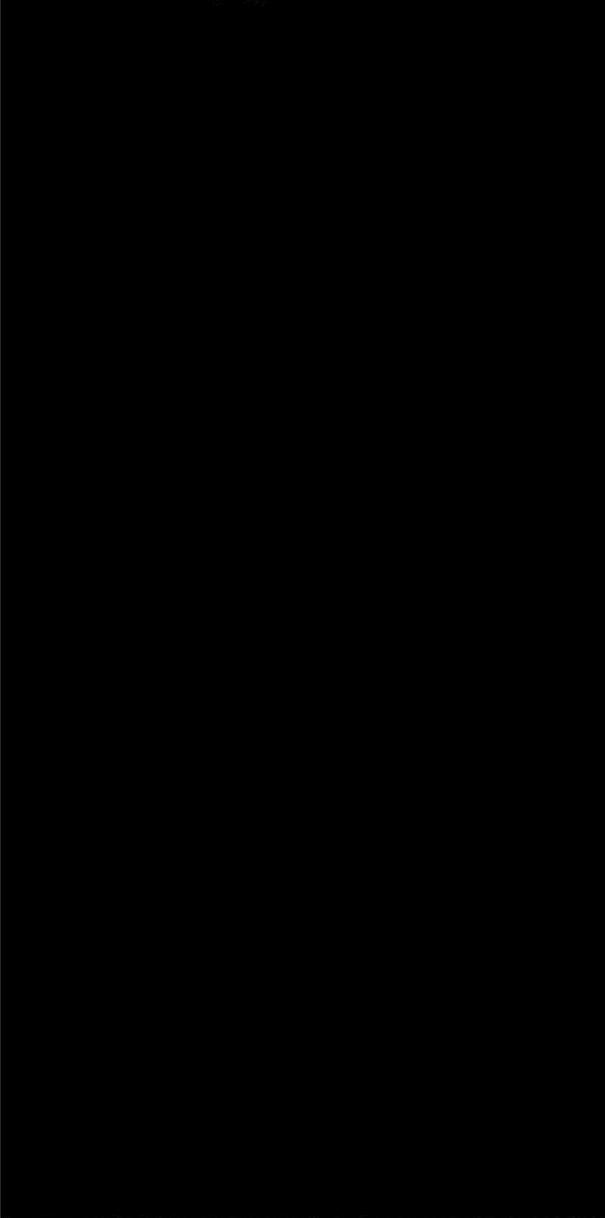
4 203	Continued From page 31 	4 203	<p><b>4 203 (continued)</b> observation for deficient hand hygiene practice were re-educated on proper hand hygiene to prevent the development/transmission of disease and infection, including washing hands prior to wearing gloves.</p> <ul style="list-style-type: none"> <li>•  was re-educated on the proper technique for hand hygiene, including (1) the order in which to provide personal care to residents (clean to dirty), and (2) the need to hand sanitize or wash hands prior to wearing gloves and to change gloves when providing care to a resident between clean and dirty tasks. <span style="float: right;">03/31/15</span></li> <li>•  was re-educated on the proper technique for hand hygiene, including the need to either hand sanitize or wash hands prior to wearing gloves during pressure ulcer wound care treatment and dressing change. <span style="float: right;">04/06/15</span></li> </ul> <p><u>Systemic changes:</u></p> <ul style="list-style-type: none"> <li>• The Infection Control Committee will meet weekly to review and document its analysis of all new infections, present on admission or acquired in the facility, to determine root-cause of the infection, analyze trends, and identify opportunities for improvement in the infection control program. <span style="float: right;">04/08/15 &amp; ongoing</span></li> <li>• All contracted rehabilitation staff will receive additional training and education on infection control policies and procedures to prevent the development/transmission of disease and infection including the (1) proper techniques for disinfecting rehabilitation equipment with the "purple top" Sani-cloths and the Virex spray, (2) required contact time for the effectiveness of the disinfectant products available to staff, and (3) location of the Rehab department's reference for infection control protocol. <span style="float: right;">05/01/15</span></li> <li>• All therapeutic recreation team staff will receive additional training and education on infection control policies and procedures to prevent the development/transmission of disease and infection, including the (1) proper technique for disinfecting recreation activity <span style="float: right;">05/01/15</span></li> </ul>	
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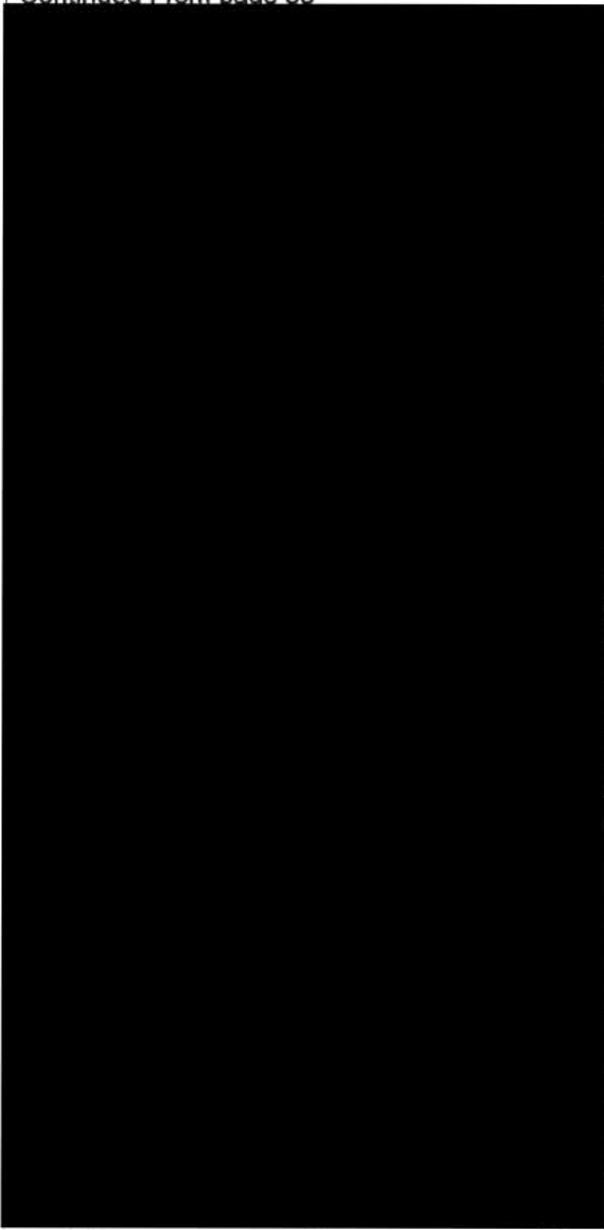
4 203	Continued From page 32 	4 203	<p><u>4 203 (continued)</u> equipment using the "purple top" Sani-cloths and the Virex spray, and (2) required contact time for the effectiveness of the disinfectant products available to staff.</p> <ul style="list-style-type: none"> <li>• A daily checklist of equipment required to be cleaned and sanitized will be implemented for the contracted Rehabilitation staff and the Recreational Therapy staff to prevent the development/transmission of disease and infection. 05/01/15</li> <li>• All licensed staff will be re-educated on infection control policies and procedures to prevent the development/transmission of disease and infection, including the (1) proper infection control technique for preparing and administering _____ (2) proper hand hygiene during _____ treatment _____ and (3) non-use of supplies that have become unusable due to contamination. 04/29/15</li> <li>• All CNA staff will be re-educated on infection control policies and procedures to prevent the development/transmission of disease and infection, including the need to either hand sanitize or wash hands prior to wearing gloves and when providing care between residents. 05/06/15</li> <li>• All Dietary staff will be re-educated on infection control policies and procedures to prevent the development/transmission of disease and infection, including washing hands prior to wearing gloves. 04/29/15</li> <li>• Food Service Supervisors will conduct daily observation rounds in all food preparation areas to ensure that Dietary staff are following proper hand hygiene to prevent the development/transmission of disease and infection, including the (1) use of gloves when handling food, and (2) washing hands prior to wearing gloves. 04/03/15 &amp; ongoing</li> <li>• The Long Term Care Monitoring Form was revised to include observations by the DON and nursing management of the procedures and technique implemented for disinfecting rehab equipment and recreation activity equipment. 03/31/15</li> </ul>	
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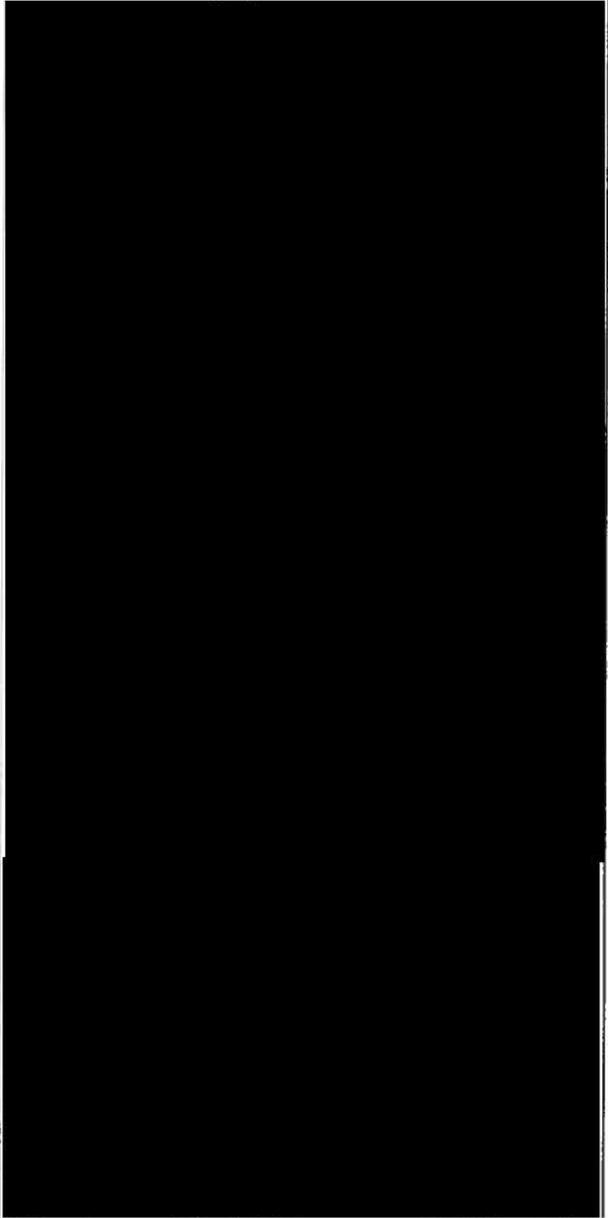
4 203	Continued From page 33 	4 203	<p><u>4203 (continued)</u></p> <ul style="list-style-type: none"> <li>Nursing management has implemented a Nursing Management Observation Log to document nursing management observations of staff providing care to residents in accordance with infection control policies and procedures to prevent the development/transmission of disease and infection and to identify opportunities for improvement with individual staff performance and/or care processes.</li> </ul> <p><u>Monitoring corrective actions:</u></p> <ul style="list-style-type: none"> <li>Data analysis and specific findings from the review of infections, trend analysis, and identification of opportunities for improvement by the Infection Control Committee will be reviewed by the DON and nursing management at the monthly Interdisciplinary Team (IDT) meetings and at the quarterly Performance Improvement Committee meetings.</li> <li>Data from the Nursing Management Observation Log will be reviewed by the DON and nursing management and at the monthly Interdisciplinary Team (IDT) meetings and at the quarterly Performance Improvement Committee meetings.</li> <li>Food Service Supervisors will report any non-compliance to the policies and procedures for proper hand hygiene to the Manager, Dietary Services, for appropriate corrective actions.</li> </ul>	<p>04/03/15 &amp; ongoing</p> <p>04/09/15 &amp; ongoing</p> <p>04/09/15 &amp; ongoing</p> <p>04/05/15 &amp; ongoing</p>
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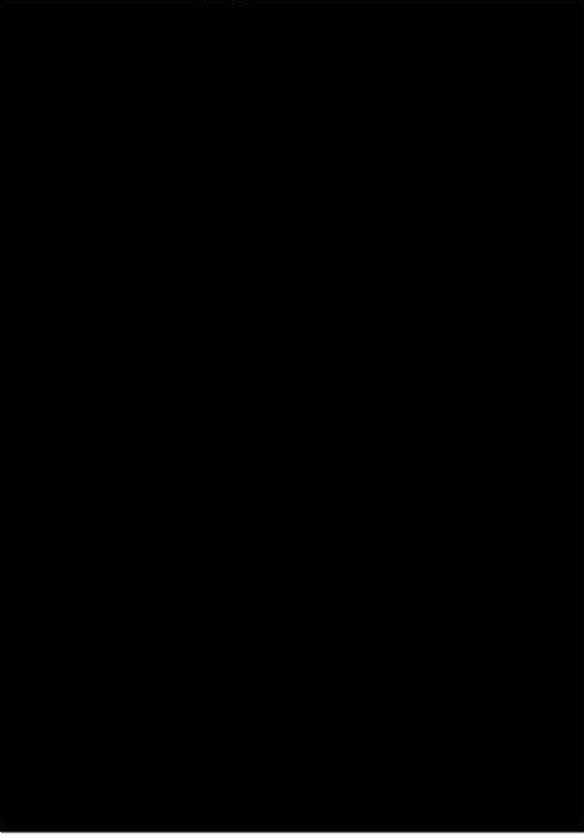
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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4 203	Continued From page 34 	4 203		
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Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>03/30/2015</b>
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4 203	Continued From page 35 	4 203		
4 218	11-94.1-55(e) Housekeeping  (e) All floors, walls, ceilings, windows, and fixtures shall be kept clean and in good repair.  This Statute is not met as evidenced by: The facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	4 218		

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4 218	<p>Continued From page 36</p> <p>Findings include:</p> <p>1. On 3/30/15 at 9:00 A.M. a tour of the facility was done [REDACTED]. On the third floor observation found the plastic base board peeling and torn on the wall across Rooms 315 through 318; between Rooms 325 and 326; and Rooms 303 and 304. Also observed wall paper peeling between Rooms 302 and 303 and in Room 313 below the window. The wallpaper on the wall across the nurse's station was scuffed on the bottom (under the hand rail). On the fourth floor the following was observed: torn wall paper and chipped paint by the resident's bed in Room 407; the wall paper outside of Room 430 under the hand sanitizer was torn; the paint on the resident's wall in Room 425 was chipped and patched; the hand rail in the hallway had a hole in it; and the wallpaper outside of Rooms 422 and 423 had scuff marks under the hand rail. Observation on the fifth floor found the following: torn wall paper across of Rooms 530 and between 527 and 528; and the wall was scuffed between Rooms 520 and 522. Observation on the sixth floor found the following: the wall outside of Room 625 had substance on the placard of the room number and the hand rail across of Rooms 606 and 607 had a hole in it.</p> <p>The signs outside of the shower room on the 4th floor had a piece of paper cut to cover the word "Men" and "Women". On the 5th floor, the signs for the shower rooms were covered with paper signs. The papers were affixed to the original sign which read, "Central Bath". The [REDACTED] reported that these signs are not acceptable as it does not look "professional".</p> <p>2. Observation of the 6th floor on 3/25/15 at 3:04</p>	4 218	<p><b>4 218</b></p> <p><u>Corrective actions:</u></p> <ul style="list-style-type: none"> <li>• Replacement of all baseboards in residents' rooms in SNF and ICF was identified and approved by the Construction Steering Committee prior to survey of facilities. 03/20/15</li> <li>• Work orders were submitted to repair/clean interior areas of the facility identified during the survey inspection including, but not limited to, repair/replace torn wall paper, and handrails; install correct signage; touch-up painting of door jams and painted surfaces; cleaning of scuffed surfaces and painting. 04/24/15</li> </ul> <p><u>Identification of other residents:</u></p> <ul style="list-style-type: none"> <li>• Facilities management and nursing management have completed a walk-through of the facility. Additional work orders have been submitted to maintain a sanitary, orderly, and comfortable environment for residents. 04/24/15</li> </ul> <p><u>Systemic changes:</u></p> <ul style="list-style-type: none"> <li>• Weekly rounding by facilities management and nursing management will be implemented to monitor progress of repair work in the SNF and ICF. 04/24/15 &amp; ongoing</li> </ul> <p><u>Monitoring corrective actions:</u></p> <ul style="list-style-type: none"> <li>• Managing Director, Facilities Management, will report the progress of the repair work in the SNF and ICF at the quarterly Performance Improvement Committee meetings. 05/01/15 &amp; ongoing</li> </ul>	
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4 218	<p>Continued From page 37</p> <p>P.M. noted the orange wallpaper on the wall by the nurse's station had several areas where the wallpaper was peeled off and scuffed with a horizontal black line running along the wall beneath the hand rails. On 3/27/15 at 9:05 A.M. during an interview with [REDACTED] [REDACTED] thought the wall with the orange wallpaper needed to be repainted. As to the condition of the door jambs with the scuff marks, [REDACTED] said [REDACTED] could request for nursing management to look at it.</p> <p>In addition, observation of the 6th floor unit found several spots where masking tape covered little plates used to cover holes in the hand rails. On 3/27/15 at 9:26 A.M. during a tour with [REDACTED] [REDACTED] also noted the hole in the hand rail across rooms 606 and 607. By the elevator area, [REDACTED] pulled off the tape on the edge of a hand rail and saw there was a hole underneath the patched area. [REDACTED] acknowledged the condition of the hand rails throughout the unit needed to be looked at.</p>	4 218		
4 243	<p>11-94.1-64(a) Engineering and maintenance</p> <p>(a) The facility shall maintain all essential mechanical, electrical, and resident care equipment in safe operating condition.</p> <p>This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain all essential patient care equipment in safe operating condition.</p> <p>Finding includes:</p> <p>On 3/30/15 at 12:01 P.M., during a tour of the rehabilitation unit, a Tectrix stationary bike was</p>	4 243	<p><u>4 243</u> <u>Corrective actions:</u></p> <ul style="list-style-type: none"> <li>The Tectrix stationary bike was sent for service and inspection was completed to ensure that the stationary bike was in safe operating condition. The Biomed label that notes the current equipment inspection date was placed on the Tectrix stationary bike on 04/24/15.</li> </ul> <p><u>Identification of other residents:</u></p> <ul style="list-style-type: none"> <li>All essential mechanical, electrical, and patient care equipment, including rehabilitation equipment, in the SNF and ICF facilities were inspected by Facilities Management to ensure that the equipment</li> </ul>	<p>03/31/15</p> <p>03/31/15</p>

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4 243	Continued From page 38  found with a Biomed label that noted the last equipment inspection was done 12/06 with "to call Biomed" written on it. Per ██████ said this bike was already in their department prior to the start of their consultant services in June of 2014. ██████ said the residents use the bike which, "has been working okay, no injuries." The last time the equipment was serviced or inspected however, was in 2006 and ██████ acknowledged it was overdue.	4 243	<u>4 243 (continued)</u> were in safe operating condition and the dates of preventive maintenance on the equipment were current.  <u>Systemic changes:</u>  • Preventive maintenance for all identified rehabilitation equipment will be scheduled on an annual basis or more frequently in accordance with manufacturer's recommendation.  • All identified rehabilitation equipment requiring preventive maintenance will be inputted into the biomedical engineering preventive maintenance program to ensure that the equipment are regularly scheduled for preventive maintenance in order to ensure that the equipment are in safe operating condition.	05/01/15 & ongoing  05/01/15
4 269	11-94.1-65(d)(6) Construction requirements  (d) The facility shall have adequate toilet and bath facilities:  (6) An adequate supply of potable running water shall be provided at all times. Temperatures of hot water at plumbing fixtures used by the residents shall be automatically regulated and shall not be below 100 or above 120 degrees Fahrenheit;  This Statute is not met as evidenced by: The facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  Findings include:  On 3/27/15 at 9:30 A.M. water temperatures were taken ██████ ██████ The water temperature in Room ██████ was 78 degrees. ██████ reported the water is cold. The water temperature in Room ██████ was 73.5 degrees. Inquired what are the parameters for hot water. The ██████ replied 110 degrees or more; however, above 120 degrees is too hot.	4 269	<u>Monitoring corrective actions:</u>  • Preventive maintenance completion rates for the rehabilitation equipment will be included in the biomedical engineering preventive maintenance program report to the Kuakini Safety Committee by the Managing Director, Facilities Management, at the quarterly meetings.	05/01/15 & ongoing

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4 269	<p>Continued From page 39</p> <p>Inquired what happened with the cold water [redacted] was not sure so an appointment was scheduled with another worker who maintains the water heater. At 10:31 A.M. an interview was done [redacted] [redacted] reported that the heater is located on the roof of the facility. The water temperature is set at 120 degrees and the return is 118 degrees and recalls that there is some work being done on the water pumps. The water temperatures were taken during a walk through of the units on 3/30/15 at 9:00 A.M. [redacted] The water temperature was taken in [redacted] the water was 106.6 degrees. The resident stated that the water is not hot and it has been this way for a long time. The water temperature was taken again in Room [redacted] [redacted] ran the water for over a minute with the temperature climbing with the highest temperature reading at 94.2 degrees.</p>	4 269	<p><b>4 269</b> <u>Corrective actions:</u></p> <ul style="list-style-type: none"> <li>The hot water temperature has been adjusted in the SNF and ICF to maintain a safe and comfortable water temperature between 100°F and 120°F.</li> </ul> <p><u>Systemic changes:</u></p> <ul style="list-style-type: none"> <li>Hot water temperature readings will be completed by maintenance staff weekly in random selected areas on each nursing floor of SNF and ICF. Hot water temperature readings will be taken in the residents' rooms, shower rooms, and the solarium. If water temperature is found to be out of the safe/comfortable zone of 100°F - 120°F, maintenance staff will adjust water temperature immediately.</li> <li>Maintenance staff will maintain a log of the hot water temperature readings taken weekly and will submit the log to the Managing Director, Facilities Management, on a monthly basis for review.</li> </ul> <p><u>Monitoring corrective actions:</u></p> <ul style="list-style-type: none"> <li>Managing Director, Facilities Management, will report the findings from the hot water temperature logs at the quarterly Performance Improvement Committee meetings.</li> </ul>	<p>04/15/15</p> <p>04/15/15 &amp; ongoing</p> <p>05/01/15 &amp; ongoing</p> <p>05/01/15 &amp; ongoing</p>