Hawaii Dept. of Health, Office of Health Care Assuranc

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 125062 | A. BUILDING: _____ B. WING _____ | 07/22/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HALE KUPUNA HERITAGE HOME, LLC | 4297A OMAO ROAD KOLOA, HI 96756 |

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| 4 000 | 11-94.1 Initial Comments<br><br>A licensure survey was conducted by the Hawaii State Agency from July 19, 2016 through July 22, 2016. | 4 000 | | |
| 4 115 | 11-94.1-27(4) Resident rights and facility practices<br><br>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:<br><br>(4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility;<br><br>This Statute is not met as evidenced by:<br>Based on observations, interview, and record review the facility failed to promote care for residents in a manner and in an environment that maintains or enhances the resident's dignity and respect in full recognition of his or her individuality.<br><br>Findings include:<br><br>[redacted] | 4 115 | RECEIVED<br>2016 AUG 17 A 11:02<br>STATE OF HAWAII<br>DON CHCA MEDICARE<br><br>[redacted]<br><br>3) A resident was not identified as harmed by this deficient practice.<br>Responsible party: Administrator and/or designee | 7/27/2016 |

Office of Health Care Assurance

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lorrette L Correa — TITLE: LNHA — (X6) DATE: 8/16/2016



[redacted]

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| 4 115 | Continued From page 1 [redacted] | 4 115 | II. All residents were assessed for use of foley bags. Any resident with foley bag will have foley bag covered and care plan updated. All residents were assessed to ensure hospital gowns and shorts were not being used. Any residents without clothing items had items replaced. All residents were assessed for grooming to ensure residents who performing own grooming do so appropriately, care plans and kardex updated. All residents were assessed for hemiparesis and care plans updated to ensure utensils are placed on unaffected side. Staff were in-serviced to knock and announce self prior to entering resident rooms.<br>Responsible party: Administrator and/or designee<br>III. An in-service to knock and announce self prior to entering resident's room was added to all new hire orientation. Facility ordered "fig leaf" type leg drainage bags to ensure drainage bag is covered at all times. Facility in-serviced all staff to ensure residents have own clothes and do not wear hospital type clothing. Facility in-serviced staff to offer hair brushing as needed. MDS Coordinator will assess residents to ensure utensil placement will be assessed and care planned as appropriate upon admission, quarterly and annually thereafter.<br>Responsible party: Administrator and/or designee<br>IV. Audits will be conducted monthly x 3 then quarterly thereafter to ensure compliance the results will be reviewed the with the Quality Assurance Performance Improvement Committee.<br>Responsible Party: Administrator and/or designee | 8/11/2016<br>8/11/2016<br>9/5/2016 |

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| 4 115 | Continued From page 2 [redacted]<br><br>3) On 7/19/16 a staff member was observed delivering a lunch tray to a resident in the room. The staff member failed to knock or announce [redacted] upon entering. | 4 115 | | |
| 4 136 | 11-94.1-30 Resident care<br><br>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:<br><br>(1) Respiratory care including ventilator use;<br>(2) Dialysis;<br>(3) Skin care and prevention of skin breakdown;<br>(4) Nutrition and hydration;<br>(5) Fall prevention;<br>(6) Use of restraints;<br>(7) Communication; and<br>(8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth.<br><br>This Statute is not met as evidenced by:<br>Based on observations, record reviews and interviews with staff, the facility failed to ensure 2 [redacted] of 5 residents at risk for the development of pressure ulcers received the care in accordance with their care plan. | 4 136 | [redacted]<br><br>II. All residents were assessed through "Pressure ulcer prevention" committee. All residents with stoplight yellow or red had care plans and kardex revised to float heels where appropriate. Staff were in-serviced to float heels per resident care plan. Staff were in-serviced to ensure all residents who cannot turn themselves are turned every two hours unless otherwise indicated by PUP committee.<br>Responsible Party: Director of Nursing and/or designee | 7/26/2016<br><br>8/12/2016 |

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| 4 136 | Continued From page 3<br><br>Findings include:<br>[redacted] | 4 136 | III. "Pressure ulcer prevention" committee updated to ensure "float heels" is a standard intervention for stoplight yellow and stoplight red residents. Staff were in-service to review kardex to identify residents who require to turn every two hours per stoplight interventions.Responsible Party: Director of Nursing and/or designee<br><br>IV. Audits will be conducted monthly x 3 then quarterly thereafter to ensure compliance. The results of the audit will be reviewed with the Quality Assurance Performance Improvement Committee. Responsible Party: Director of Nursing and/or designee | 8/15/2016<br><br>9/5/2016 |

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| 4 136 | Continued From page 4 [redacted] | 4 136 | | |

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| 4 136 | Continued From page 5 [redacted] | 4 136 | | |

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| 4 136 | Continued From page 6 [redacted] | 4 136 | | |
| 4 159 | 11-94.1-41(a) Storage and handling of food<br><br>(a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions.<br><br>(1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and<br><br>(2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage.<br><br>This Statute is not met as evidenced by:<br>Based on observations and interview, the facility failed to distribute and serve food under sanitary conditions.<br><br>Findings includes:<br><br>1) On 7/19/2016 at 9:17 AM observed during a kitchen tour with the Food Services Director (FSD) a 1/2 gallon of orange juice opened with no date opened; a plastic 2 oz. nutmeg spice container with no year opened; a plastic 2 oz. celery seeds spice with an unreadable faded date opened.<br>[redacted] | 4 159 | I. 1) Expired food items were discarded immediately upon notification of deficient practice.<br>2) Staff was in-serviced on proper handwashing during meals on 7/22/2016.<br>3) Jalousie pane was replaced. Frame of window was cleaned. U shaped pipe replaced.<br>Responsible Party: Administrator and/or designee<br><br>II. No residents were identified as harmed by this deficient practice.<br>Responsible Party: Administrator and/or designee<br><br>III. Dating and labeling in-service completed with all dietary staff. Staff in-serviced on proper handwashing practices. Cleanliness around windows, jalousie replacement, and storage equipment checks to kitchen sanitation rounds.<br>Responsible Party: Administrator and/or designee<br><br>IV. Audits will be conducted monthly x 3 then quarterly thereafter to ensure compliance. The results of the audit will be reviewed with the Quality Assurance Performance Improvement Committee.<br>Responsible Party: Administrator and/or designee | 8/9/2016<br><br>8/9/2016<br><br>8/15/2016<br><br>9/5/2016 |

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| 4 159 | Continued From page 7<br>[redacted]<br>3) On 7/21/2016 at 12:49 PM observed in the Ilima kitchen above the kitchen counter used for food prep, the kitchen window was missing the bottom jalousie pane and there was a screen covering the window. Observed dust was clinging to the window frame. On that same kitchen side was a "U" shaped pipe used to hang cooking ladles, large and small whisks. The pipe on which the ladles and whisks hung had white peeling paint, black spots, and dust clinging to the pipe. | 4 159 | | |
| 4 174 | 11-94.1-43(b) Interdisciplinary care process<br><br>(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 services, restorative care, preventative care, dietary or nutritional requirements, and resident/family education.<br><br>This Statute is not met as evidenced by:<br>Based on observation, record review and interview with facility staff, the facility failed to develop a care plan for 2 of 18 residents reviewed in Stage 2. | 4 174 | [redacted] | 8/9/2016 |

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| 4 174 | Continued From page 8<br><br>All references to Minimum Data Set (MDS), Care Area Assessment (CAA) relate to the State specified long term care resident assessment tool.<br><br>Findings include:<br>[redacted] | 4 174 | II. All residents admitted in the last 30 days had care plans updated to ensure adjustment to facility was addressed. All residents were assessed for oral care problems and care plans updated to reflect oral status. MD notified as needed. All residents were assessed for hemiparesis and care plans updated to ensure measures in place to maintain ADLs.<br>Responsible Party: Administrator and/or designee<br><br>III. Social service director was in-serviced on assessment and care plan for new admission adjustment to facility. MDS Coordinator was in-serviced on assessment and care planning related to maintenance of ADLs in person with hemiparesis and oral care needs. Licensed staff were in-serviced on oral assessment accuracy and intervention.<br>Responsible Party: Administrator and/or designee<br><br>IV. Audits will be conducted monthly x 3 then quarterly thereafter to ensure compliance the results will be reviewed the with the Quality Assurance Performance Improvement Committee.<br>Responsible Party: Administrator and/or designee | 8/9/2016<br><br>8/12/2016<br><br>9/5/2016 |

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| 4 174 | Continued From page 9 [redacted] | 4 174 | | |

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| 4 174 | Continued From page 10 | 4 174 | | |

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| 4 174 | Continued From page 11 [redacted] | 4 174 | | |
| 4 203 | 11-94.1-53(a) Infection control<br><br>(a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases | 4 203 | | |

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| 4 203 | Continued From page 12<br>that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste.<br><br>This Statute is not met as evidenced by:<br>Based on observations, interviews, and policy review the facility failed to maintain a safe sanitary and comfortable environment to help prevent the development and transmission of disease and infection.<br><br>Findings include:<br><br>1) On 7/19/2016 1:49 PM observed on the Ilima's unit shared bathroom wedged between the toilet grab bar and wall were 2 pink bed pans and one urinal hat. Each bed pan was labeled with a different resident name, the urinal hat was not labeled. The CNA stated one resident's bed pan was for a resident who was still on the unit; the other labeled bed pan belonged to a resident who was no longer on the unit. When asked about the policy for storage of bedpans, the CNA replied "suppose to be in a black bag and in the resident's room". A review of the facility policy titled, "Bedpan and Urinal Use" states, "All equipment should be labeled with residents name and dated to ensure one person use. Equipment should be placed in a plastic bag for protection".<br><br>2) On 7/21/2016 at 8:26 AM observed the Kitchen Supervisor (KS) hand washing. The KS applied soap, lathered and rinsed under running water for less than 15 seconds. When asked if the observed hand washing followed the 20 second recommendation posted above the sink the KS said "yeah" but proceeded to do a second | 4 203 | I. 1) Bed pans were discarded and replaced immediately upon notification of deficient practice. New bed pans and urinal hat were labeled with resident name and date. Storage bags were provided for sanitary storage of personal items.<br>2) Handwashing in-service was provided to the kitchen supervisor.<br>3) Handwashing in-service provided to all nursing staff working in Makalapua building. Staff in-serviced to be back on the unit 15 minutes prior to the start of meal service.<br>Responsible Party: Director of Nursing and/or designee<br>II. All residents that use bedpans and urinals had items replaced with new equipment with name and date. No residents were identified as being harmed by handwashing. No patterns noted in infection control information over last quarter.<br>Responsible Party: Director of Nursing and/or designee<br>III. Staff were in-serviced on bed pan labeling with names and dates and appropriate storage of equipment related to infection control practices. Staff were in-serviced on appropriate hand washing practices. Makalapua staff were in-serviced to take breaks and return to floor at least 15 minutes prior to the start of meals. The policy and wall signs were revised to relect 20 seconds of scrubbing time per recommendations by the CDC.<br>Responsible Party: Director of Nursing and/or designee | 8/9/2016<br>8/9/2016<br>8/12/2016 |

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| 4 203 | Continued From page 13<br>hand washing. The Hand Washing poster above the sink states, "Briskly rub hands for twenty seconds; then rinse forearms and hands". The facility hand hygiene policy states, "wash well under running water for a minimum of 15 seconds, using a rotary motion and friction. Rinse hands well under running water".<br><br>3) On 7/19/2016 at 11:30 A.M. an observation on Makalapua unit was made in the dining area at lunch time. Staff present were a Certified nurse aide (CNA) and a registered nurse (RN). CNA was performing multiple tasks including setting the table with silverware, placemats, and napkins. [redacted] was also placing residents at the dining table, answering bathroom call lights, resident room call lights. The RN was preparing medications to be given, answering bathroom call lights, answering resident call lights, answering residents' inquiries.<br><br>Observation was made of the CNA when [redacted] placing silverware on the table, [redacted] went to a room to bring a resident to the table. [redacted] then answered a call light and brought another resident to the table without hand washing or hand sanitization. The RN was asked regarding the staffing ratio in relationship to the posting that stated (1 RN) and (2 CNA's). The RN stated that one CNA was eating. At 11:42 A.M. seven residents were at the table to eat. At 11:58 A.M. six other staff members from the facility came to help serve the residents and assist the two staff members. The second CNA returned from lunch.<br><br>On 7/20/2016 at 10:00 A.M. interview with Director of Nursing (DON). Explained to the DON the situation of the dining observation and | 4 203 | IV. Audits will be conducted monthly x 3 then quarterly thereafter to ensure compliance. The results of the audit will be reviewed with the Quality Assurance Performance Improvement Committee. Responsible Party: Director of Nursing and/or designee | 9/5/2016 |

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| 4 203 | Continued From page 14<br>compromise of infection control practices. DON acknowledged that "it probably was not a good time for the CNA to take a lunch at a busy time," DON said that she would look at this. | 4 203 | | |