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	125055	A. BUILDING: _____ B. WING _____	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HI'OLANI CARE CENTER AT KAHALA NUI	4389 MALIA STREET HONOLULU, HI 96821

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4 000	11-94.1 Initial Comments A licensure survey was conducted from 4/25/17 to 4/18/17.	4 000		
4 105	11-94.1-22(g) Medical record system (g) All entries in a resident's record shall be: (1) Accurate and complete; (2) Legible and typed or written in black or blue ink; (3) Dated; (4) Authenticated by signature and title of the individual making the entry; and (5) Written completely without the use of abbreviations except for those abbreviations approved by a medical consultant or the medical doctor. This Statute is not met as evidenced by: Based on record review, interview with staff member and a review of the facility's policy and procedures, the facility failed to ensure 2 of 8 medical records reviewed were complete. Findings include: 1) Cross Reference to §11-94.1-30. The record review for Resident #3 found the facility was monitoring the resident's behavior related to the use of an antidepressant. The behaviors being monitored included: sad facial affect, isolation/refuse participation in activity and negative verbalization. A review of January 2017,	4 105		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 5/28/2017

6/2/17: Copy to KW i kgb

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4 105	Continued From page 1 February 2017 and March 2017 found the documentation was not complete, staff members failed to initial their entries and there was also missing documentation for various days/shifts. The review found for the month of January 2017 staff members did not initial documentation for sad facial affect on the following days/shifts: January 2, 3, 6, 7, 8, 10, 13, 18, 20, 21, 22, 23, 27, 28, 29, 30 and 31. The staff members did not initial documentation on the following days/shifts related to isolation/refuse participation in activity for the following: January 2, 3, 6, 7, 8, 10, 18, 20, 21, 22, 23, 27, 28, 29, 30 and 31. The staff members did not initial documentation for negative verbalization on the following days/shifts: January 2, 3, 6, 7, 8, 10, 20, 21, 22, 23, 27, 28, 29, 30 and 31. There was no documentation of behavior or initial on the following days: January 13 (x 2) and 24. A review for the month of February 2017 found missing documentation for February 26 and 27. The staff member did not initial documentation on February 15 and 17. A review for the flow sheet for March 2017 found no documentation for number of behaviors for negative verbalizations with staff initials on the following dates/shifts: March 3, 4, 5, 6, 7,11, 12, 13, 14,16, 17, 26, 27, 28, 29, 30, and 31. Further review found no staff initials for the three behaviors on the following dates/shifts: March 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 16, 17, 26, 27, 28, 29, 30 and 31. 2) Record review done on 4/25/17 at 9:37 A.M. found a physician's order for Resident #12 for effexor, 100 mg. twice a day for diagnosis of depression with a start date of 1/11/16. Further	4 105	The Director of Nursing and Assistant Director of Nursing conducted in-service training with the nursing staff regarding behavior monitoring, monitoring side effects and use of antidepressants/psychotropic, antipsychotic drugs for the affected Resident as well as ensuring that documentation is completed and monitoring logs filled out and endorsed appropriately. Hi'olani has created a QAPI Antipsychotic subcommittee which includes the DON, ADON associate medical director, social worker and others to evaluate and monitor the use of medications, drug regimens and to review Resident behaviors and interventions. The Director of Nursing and Assistant Director of Nursing will ensure that all resident behaviors, the use of drugs and appropriate documentation are monitored, complete and that appropriate actions are taken. Completion date: May 10th, 2017 5/10/17	

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4 105	Continued From page 2 record review was done on 4/27/17 at 8:11 A.M. The facility developed a "Behavior/Intervention Monthly Flow Record" for Resident #12 for the use of effexor. The identified behaviors that the facility monitored the resident for included: crying/sad facial expression, negative behavior and poor appetite. The flow record for the month of February is missing documentation for the number of episodes and initials for the following dates/shifts: February 11, 21, 23, 24, 25, 27, and 28. The flow record is missing initials for the following entries: February 2, 3, 4, 13, 14, 17, 18, 19, 20, 21, 23, 24, 26, 27, and 28. A review for the month of March 2017 also found missing documentation on the following dates/shifts: March 4, 5, 6, 7, 9, 11, 12, 13, 14, 16, 17, 20, 21, 26, 27, 28, 29, 30, and 31. Concurrent review with Staff Member #252 on 4/27/17 at 12:45 P.M. confirmed the missing documentation for Residents #3 and #12. A review of the facility's policy and procedure provided by the facility on 4/28/17 at 10:00 A.M. for "Medical Records" notes "Medical record entries (either paper or electronic) must be dated, the time entered and be manually or electronically signed and/or initialed".	4 105		
4 115	11-94.1-27(4) 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	4 115		

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4 115	Continued From page 3 rights of each resident, including: (4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility; This Statute is not met as evidenced by: Based on a confidential interview with a resident, the facility failed to provide care for a resident in a manner that promotes resident's quality of life. Findings include: On 4/26/17 at 7:17 A.M. a confidential interview was conducted with a resident. The resident reported pushing the call light and at times having to wait five minutes before a staff member responds to the light. The resident reported the call light is being pressed for assistance with toileting. The resident reported there are times the staff member responds too late resulting in bowel and/or bladder incontinence. Observation on 4/27/17 at 9:06 A.M. at the nurse's station, the call light was heard ringing. At the station, there is a monitor which displayed the room number 594A, bathroom and 6:51. Observation at 9:13 A.M. of room number 594 found the residents were not in their beds and the bathroom door was closed. Also noted two other entries displayed on the screen: room number 593A, routine and the time was 6:57 and room number 593A, routine and the time was 6:58. Upon return to the nurse's station a staff member was observed to check the screen and headed down the hall. The call light ringing for room 594 stopped. On 4/27/17 at 2:20 P.M. an interview and concurrent observation was done with Staff	4 115	Residents affected by the noted deficient practice and concerned about slow call response times, were scheduled, as an ongoing part of their care plan, to be visited on a more frequent, regular basis prior to their need to call for assistance. This action was completed on 4/29/17. The Director of Nursing and Assistant Director of Nursing conducted in-service training with all of the aides and staff nurses regarding the need to ensure that Residents are visited on a regular basis as a part of the daily rounding and emphasizing the importance of responding to a Resident call for assistancewithin a reasonable period of time. Residents requiring more frequent staff visits to assist with toileting or incontinence will be scheduled for regular assistance visits based upon their identified needs. While Hi'olani sets a target of responding to all Resident calls within five minutes, with an actual computer tracked response time of two and a half minutes or less there are times when a response might take longer, as such, the Director of Social Services interviews Residents throughout the year, regarding their satisfaction with timely staff response,reviews this with Nursing and care plans appropriate actionto help the Resident on a timely basis with their needs. Resident call response times are tracked and reported to the QAPI Committee, aides, nursing staff and requesting family members along with recommendations for action. Lastly, a question directed to the Resident and family member's satisfaction with call time responses will be added to the care plan meeting summary report. The Director of Nursing and Assistant Director of Nursing will ensure that each Resident's calls are handled within a timeframe acceptable to the Resident. Completion Date: May 10th, 2017 5/10/17	

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4 115	Continued From page 4 Member #268. The staff member clarified the monitor will display information when the call light is pressed. The information provided includes the room number, location and the time (how long the bell was activated). The facility failed to respond to a resident's call light for assistance with the restroom resulting in incontinence for an alert resident who was admitted for short-term rehabilitation.	4 115		
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 development when the facility provides care to infants, children, and youth. This Statute is not met as evidenced by: Based on record review and interview with staff members, the facility failed to ensure 1 (Resident #3) of 5 residents sampled for drug regimen review was free from unnecessary drugs. Findings include:	4 136		

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4 136	Continued From page 5 Cross Reference to §11-94.1-22(g). Resident #3 was admitted to the facility on 2/16/16 from an assisted living setting. Resident #3's current diagnoses include: late onset of [redacted], frequent falls, overactive bladder, hypertension, chronic kidney disease (Stage III), peripheral neuropathy and chronic back pain due to mild L2 superior endplate compression. A record review on 4/25/17 at 9:40 A.M. found a physician's order for zoloft 100 mg. tablet (sertraline HCL), increase to 100 mg. by mouth daily from 3/27/17 for a diagnosis of depression. Further review found "Behavior/Intervention Monthly Flow Record" for January 2017, February 2017 and March 2017 documenting sad facial affect, isolation/refuse participation in activity and negative verbalization as the identified behaviors for monitoring the resident's depression. The documented medication was celexa for January 2017 and February 2017. Further review found a form entitled "Monitoring Log for Side Effects of Antipsychotics" which included the following side effects: suicidal thoughts or ideation; excessive sedation (drowsiness) and increased restlessness. A review of the care plan found a plan for psychotropic drug use. The plan notes Resident #3 was on cymbalta for back pain and depressed mood; however, medication was tapered from 20 mg. daily to every other day on 1/16/17 then discontinued after a week. Also noted Resident #3 was started on zoloft (antidepressant) on 2/27/17 and due to signs and symptoms of depression zoloft was increased on 3/27/17. The interventions included to daily monitor for the side effects of zoloft included daytime drowsiness,	4 136	Nursing staff immediately disposed of the expired biological. Additionally, staff contacted the pharmacy and pharmacy consultant to address the issue of disparity between physician orders and what was noted on the medication blister pack. The Director of Nursing and Assistant Director of Nursing conducted in-service training with all nursing staff emphasizing that established procedures for the timely cross checking of medications with the attending physician's orders must be followed at all times. If discrepancies are noted, charges nurses will contact the pharmacy immedicably and have the proper medication dosage delivered. Included in this in-service, was the requirement to follow established protocols of labeling and disposing of expired medications. The DON, ADON and consultant pharmacist will periodically audit medications and the associated physician orders to ensure that medication management procedures are being followed. The Director of Nursing and Assistant Director of Nursing will ensure that drug records are maintained and include this subject in routine nurse staff meetings and in in-service training sessions. Completion date: May 10th, 2017	5/10/17

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4 136	Continued From page 6 dizziness, headache, hallucination and agitation. Further review of the Behavior/Intervention Monthly Flow Record found for the month of January 2017, February 2017 and March 2017 there is missing documentation of staff members' initial for their shifts and missing entries for documentation of the number of behavior episodes for each shift. Although there was an increase of zoloft on 3/27/17, the behavior flow records does not indicate an increase in behavioral episodes. The form for February 2017 notes one episode of negative verbalization on 2/18/17 during the evening shift. The rest of the entries are documented with 0 (zero) number of episodes. On 2/27/17 Resident #3 was started on zoloft. A review of the resident's behavior monitoring flow record for March 2017 found 24 missing entries across three shifts for the behavior of negative verbalization. Also for the month of March there are 51 entries over the three shifts for the three identified behaviors. On 4/27/17 at 12:45 P.M. an interview was conducted with the Director of Nursing (DON). The DON was queried regarding how the facility monitors the resident for the side effects related to the use of an antidepressant. The DON responded the facility utilizes the "Monitoring Log for side Effects of Antipsychotics". The DON also reported the side effects for the use of an antidepressant includes suicidal ideation, change in appetite and behaviors as well as nausea and vomiting. The facility failed to adequately monitor Resident #3's behaviors related to the use of an antidepressant. Also, the facility failed to	4 136		

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4 136	Continued From page 7 adequately monitor the side effects for the use of zoloft. The monitoring log for side effects addresses the side effects related to the use of an antipsychotic, not an antidepressant. Also the behavior monitoring log has incomplete documentation.	4 136	Kahala Nui kitchen staff took immediate action to dispose of the expired food items. Staff also removed food items stored on the floor and placed the items on the appropriate above floor shelving, cleaned and dried the freezer floor and cleaned the freezer fan. The freezer fan was subsequently tested and found to be operating correctly. Staff in-service training was conducted regarding the labeling and monitoring of both fresh and packaged food products to ensure that nothing is kept beyond the expiration dates. Proper food storage, managing food freshness, monitoring expiration dates, proper storage procedures and freezer and other equipment maintenance and management will be reinforced during regular in-service training session throughout the year. The Executive Chef and The Director of Dining Services and assigned staff will conduct periodic inspections and "spot" checks of all food items, storage, refrigeration and freezer units to ensure products are fresh and stored properly. These inspections will be reviewed with the QAPI Committee at the monthly meeting. The Director of Dining Services and the Executive Chef are responsible for ensuring that this deficient practice does not reoccur. Completion date: June 1st, 2017.	6/1/17
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (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 (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. This Statute is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain and store foods in a sanitary manner. Findings include: 1) During an initial tour of the kitchen on the morning of 4/25/17 at approximately 8:30 A.M. found expired food items and food items without expiration dates noted. Two food items were being stored in the walk in refrigerator but was expired: Oriental dressing, 1.5 gallons, expired 2/217; Ken's Tartar Sauce, expired 2/3/17. Four food items were stored in the walk in refrigerator which didn't have expiration dates: LaScala	4 159		

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4 159	Continued From page 8 dressing, no expiration date; Chicken base, no expiration date; Demi Glace, no expiration date; Beef Glace, no expiration date. An interview of Staff #206 on the afternoon of 4/27/17 at approximately 2:30 P.M. revealed the facility went through the above named dressings/sauces quickly. The Staff #206 stated the LaScala dressing, Chicken base, Demi Glace, and Beef Glace came in a large cardboard box where the expiration dates were noted. When the items are removed from the cardboard box, the expiration dates weren't noted on the individual food items. Staff #206 stated he would need to look at this issue and figure out how they'll transpose that information onto the individual containers. 2) A follow visit to the kitchen on the afternoon of 4/27/17 at approximately 2:30 P.M. found the facility kept a walk in freezer outside. The outdoor freezer had foods stored on the floor of the freezer. Areas of the floor in the outdoor freezer were iced and slippery. The ceiling of the outdoor freezer was frosted. The outdoor freezer's fan was found to have a lot of ice build up. The fan sounded loud and the air flow was limited due to the large amount of ice build up. An interview of Staff #206 on the afternoon of 4/27/17 at approximately 2:45 P.M. revealed the staff were expected to maintain the outdoor freezer and keep it clean. On the afternoon of 4/27/17 at approximately 2:45 P.M., Staff #206 was asked for a policy for maintenance of the kitchen equipment. At the time of exit, the policy was not provided to the surveyor.	4 159		

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4 269	Continued From page 9	4 269		
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: Based on observations, staff interview and facility policy review, the facility failed to maintain safe temperature levels in a two resident's rooms (Rooms 488 and 490). Findings include: During a tour of the facility on 4/25/17 at approximately 12:20 P.M., residents' rooms 488 and 490 had high water temperatures at the sinks and showers. When the surveyor turned the water on to the hottest temperature, the water felt too hot to leave a hand under it. On 4/25/17 at 1:15 P.M., Staff #234 and #229 both came to the fourth floor to check the water temperatures. Staff #234 used the facility's laser thermometer to check the temperature in Room 490. The shower in Room 490 went to 120.8 degrees Fahrenheit. On the fifth floor, the basin in Room 594 registered at 121.5 degrees Fahrenheit. A review of the facility's water temperature logs from December 2016 through present found the temperatures were logged above 120 degrees on	4 269	Building Operations adjusted the maximum temperature setting at the main water terminal from 120 degrees to 115 degrees. Additionally, new testing thermometers were purchased and arrangements made to have the devices calibration tested on a quarterly basis to ensure that the temperature reading are accurate. A written procedure/staff guideline was established and staff in-serviced to take immediate steps to correct water temperature variations which fall outside the maximum allowed. Monitoring of temperatures will continue on a regular basis and a temperature log will be maintained. The Building Operations Director and Supervisor will ensure that water temperatures remain within the ranges set by state standards and review this issue periodically with the Safety Committee. Completion date: May 3rd, 2017	5/3/17

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4 269	Continued From page 10 multiple occasions. On 12/16/16 in Room 480, the temperature measured 121 degrees and 123 degrees Fahrenheit for the shower and basin respectively. On 2/3/17 in Room 572, the temperature measured 120 degrees and 121 degrees in the shower and basin respectively. On 2/17/17 in Room 478, the temperature measured 121 degrees in both the shower and basin. The logs did not contain documentation of interventions when the temperatures were measured above 120 degrees. An interview of Staff #234 on the afternoon of 4/25/17 at approximately 1:15 P.M. revealed the facility kept the thermostat at 115-120 degrees. Staff #234 further noted the facility utilized an outside Contractor to maintain their hot/cold water mixing valves. A review of the facility's policy titled, "[Facility's] Thermostatic Valves" with effective date of 6/20/12 revealed, "The acceptable temperature range for hot water is between 105 degrees and 120 degrees Fahrenheit." The policy further noted, "F. If the temperature falls outside the acceptable range (either too cold or too hot) an adjustment will be made at the source (three mixing valves in the machine room)".	4 269		