Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Hokulaki Senior Living, L.L.C.	**CHAPTER 100.1**
Address: **45-217 A William Henry Road, Kaneohe, Hawaii 96744**	**Inspection Date: November 19 and 20, 2015 Annual**

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance. **FINDINGS** SCG #1 – No current tuberculosis clearance. Last completed 7/8/14.	See Attached	
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1 – No physician order to discontinue hospice medication and resume medication ordered by the primary care provider. For example, "morphine sulfate (concentrate) by mouth," "Fleets enema" and "bisacodyl laxative rectal suppository."	See Attached	11/20/15

PLAN OF CORRECTION

Facility's Name: Hokulaki Senior Living, LLC

Date of Inspection: November 19 and 20, 2015 (Annual)

11-100.1-9(b)

SCG #1 had a Tuberculosis Clearance done on 09/08/2015 from her PMD's office. The TB Clearance form was not in the Care Home Folder but was handed to the Nurse Consultant on 11/20/15 when she asked for it. Form was placed in the Care Home folder at that time.

PCG created a 'Personnel Form' Annual Checklist which include but not limited to TB Clearance; CPR and First Aid, Physical Exam, etc. PCG and/or designated substitute will check 'Personnel Form' every 3 months to avoid the same mistake in the future.

Completion Date: November 20, 2015

RN, PCG

PLAN OF CORRECTION

Facility's Name: Hokulaki Senior Living, LLC

Date of Inspection: November 19 and 20, 2015 (Annual)

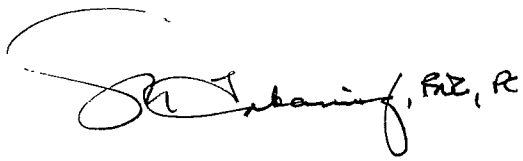
11-100.1-15(e)

Resident #1 was discharged from Hospice Care by Hospice MD from a Hospice Care Agency several days prior to inspection date. Hospice medications were also discontinued but Hospice Nurse did not send or fax a copy of the discontinuance of hospice medications. PCG resumed medications prescribed by PMD after discharged from Hospice Care. PCG did not remove MAR and charting reflecting that Resident #1 was in Hospice care since the discharge only happened approx. 2 weeks before inspection.
The Hospice nurse was called to inform her that a discharge order of the hospice meds should have been faxed to the care home. Resident #1's PMD wrote the order of hospice care discharge and discontinuance of hospice meds on 11/20/15.

Completion Date: 11/20/15

PCG and RN, CM conferred about medications that CM listed in the care plan without a doctor's order. Medications, Luxiq and Zinc Oxide were copied in error by CM from an old care plan of Resident #1 when she updated it. The care plan was corrected by CM on 11/26/15

In the future, PCG and substitute caregivers will make sure that all discontinued medications order will be in the resident's medical record and be verified 2-3 times by PCG and designated substitute. PCG and substitute caregivers will also communicate better to the Hospice Agency's nurse when it comes to physicians's medication and treatment orders as different hospice agencies have different rules that can be confusing. Completion Date: 11/26/15



PLAN OF CORRECTION

Facility's Name: Hokulaki Senior Living, LLC

Date of Inspection: November 19 and 20, 2015 (Annual)

11-100.1-15 (Continuation)

-Dosage of Tylenol, "2 tablets" was missed typing on the Physician's order form signed by the PA and PMD during clinic visits. Though it was reflected on the Medication Administration Record (MAR) and the medication label. The 2 'Physician's Order Forms dated 9/11/15 and 11/16/15 were brought to Resident #2's PMD by a Hokulaki caregiver on 11/24/15 to insert the dosage on the Tylenol medication "2 tablets" and initialed both forms.

In the future, the list of medications will be carefully listed and reviewed by PCG and a designated substitute caregiver making sure to enlist the 5-Rs of medication basic requirements for safe, accurate medication administration which include but not limited to the right name of the drug or medication; the right dosage, the right name of the resident, the correct route and the right time.

Completion Date: 11/24/15

The antibiotic order for Resident #2, Nitrofurantoin mono which was ordered every 12 hours x 10 days was written by PCG on the MARs for July and August 2015, as 0730 and 1830, because first, according to pharmacy literature on the drug and the 'Nursing 2015 Drug Handbook', it specifically states "Give drug with food or milk to minimize GI distress and improve absorption" and since it was only about 1 hour gap, PCG wrote it as closer to the dinner time.

In the future, PCG or designated substitute will call PMD or any doctor ordering antibiotics or any other drugs that has to be taken with food to have a clarification order on that particular drug or medication, if ordered Q12H, and transcribe order to the MAR as ordered.

Completion Date: 3/6/16

Sabaniog, RN, PCG

	Resident #1 – No physician order for "Luxig foam" and "zinc oxide" reflected in the care plan. Resident #2 – "Tylenol Acetaminophen (325 mg tablets) po every 4 hours PRN for pain" ordered 11/16/15 and 9/11/15; however, the medication record and medication label reflected "two (2) tabs." Resident #2 – "Nitrofurantoin mono (Macrobid) 100 mg i cap every 12 hours x 10 days" ordered 7/30/15; the July 2015 and August 2015 medication records reflected the medication was taken at "0730" and "1830" (6:30 p.m.)	See Attached	11/26/15 11/24/15 3/6/16
☒	§11-100.1-17 Records and reports. (a)(1) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: Documentation of primary care giver's assessment of resident upon admission; **FINDINGS** Resident #1 – The admission assessment completed on 10/21/15 noted resident needed "assist" with bathing, grooming, dressing, diet, toileting with commode; however, on 10/23/15, the Case Manager documented the resident required maximum two (2) person transfer assist, wheelchair for mobility and required spoon feeding.	See Attached	12/11/15
☒	§11-100.1-17 Records and reports. (b)(4) During residence, records shall include: Entries describing treatments and services rendered; **FINDINGS**		11/30/15

PLAN OF CORRECTION

Facility's Name: Hokulaki Senior Living, LLC

Date of Inspection: November 19 and 20, 2015 (Annual)

11-100.1-17 (a)(l)

Resident's assessment was done to the best of knowledge as the PCG saw it at the time of admission / readmission to the facility. Resident #1 was discharged from the hospital on a 'Level of Care' that indicated she was an 'ARCH' level signed by the discharging physician so she did not require a Case Manager at that time. As any resident who comes back from the hospital, he or she is still usually very weak due to deconditioning but usually improve after a few days. PCG noted Resident #1 as very slow recovering as she could not drink her honey-thickened fluids thru a straw, etc. and the family were being talked to of resident being admitted to Hospice Care on the second day after re-admission, 10/22/15. Resident #1's PMD and an RN, CM were called by PCG to report present status and changes that were noted. PCG made appointment to bring Resident #1 to her PMD and RN, CM to visit Resident #1 in the care home for reassessment and re-evaluation. Resident #1 was brought to PMD on 10/23/15 for reassessment of present status. Level of Care was changed from Care Home level to ICF by

PMD at that time. RN, CM visited Resident #1 in the care home on 10/23/15 in the afternoon after Resident #1 was already seen by PMD.

Resident #1's Level of Care was already changed to ICF level when RN, CM visited her on 10/23/15. PCG and caregivers don't want any falls to happen, so to prevent falls, residents are usually helped in the beginning more than usual when transferring or in mobility especially when newly admitted/re-admitted from the hospital due to deconditioning. RN, CM wrote what she saw were being done in the care home when she visited on her comprehensive assessment form.

In the future, the PCG will call the aid of the RN, CM to re-evaluate the level of care of the resident on the same day of admission / re-admission to make sure that comprehensive assessment is consistent with the PCG's initial assessment. The assessment admission forms will be carefully filled out with PCG and RN, CM collaborating together in the admission / readmission of residents especially if coming from the hospital to better service the resident in creating the service plan of care or care plan.

Completion Date: December 11, 2015

[signature], RN, PCG

PLAN OF CORRECTION

Facility's Name: HOKULAKI SENIOR LIVING, LLC
Date of Survey: November 19 and 20, 2015 (Annual)

11-100.1-17(a)(1)

In the future, to ensure that the same deficiency will not happen again:

First, when picking up resident from the hospital for admission/readmission, the PCG will make sure that the Level of Care assessed by the Hospitalist Physician assessing and signing for the Level of Care form reflects the assessment of the PCG as such while still in the hospital and before discharged. If the Level of Care does not match with present assessment, the physician and discharge planner will be notified at that time, and the Level of Care form will be changed to the more appropriate level of care before the resident is discharged from the hospital or facility.

If however, the resident has been assessed as a Care Home Level and starts progressing to a higher level of care, the PCG will document extensively in the Nurse's Progress Notes of any and all changes that may or will place the resident to a higher level of care. After the assessment is made and it warrants for a higher level of care, the PMD will be notified and bring resident to his office as soon as possible for reassessment so that the PMD can change the level of care appropriately. A case manager that the resident's family, legal representative chose will be called in to assess the newly admitted or readmitted resident so that the proper plan of care will be prepared for the resident. The CM's comprehensive assessment will be consistent with the PCG's initial assessment.
Completion date: 12/11/15

J. Tabaniag, RN, PCG

PLAN OF CORRECTION

Facility's Name: Hokulaki Senior Living, LLC

Date of Inspection: November 19 and 20, 2015 (Annual)

11-100.1-17 (b)(4)

When an order is written by a physician to "Crush Medications", Hokulaki PCG or substitute calls the pharmacist of the drug store where the medications were picked up from and ask which medications are crushable or not. Then it is usually noted by the drug name at the end of the entry on the MAR, if it is crushable or not. On the entry, it would indicate, "Do not crush or chew." Hokulaki staff is also using the "Nursing 2015 Drug Handbook" as a back up to review current medications aside from Drug Information sheet that comes with the medication when picked up from the pharmacy. Crushable medication drugs were already included in the documentation on the November 30, 2015 progress notes entry.

In the future, PCG and caregivers will continue to identify crushable medications on the MAR but also to document on the progress notes which medications are being crushed to prevent mistakes that will be made by staff and to alert the case manager for proper entry into the care plan.

Completion Date: November 30, 2015

RN, PCE

	Resident #1 – No documentation that identifies medication(s) that are crushed.	See Attached	11/30/15
☒	§11-100.1-23 Physical environment. (g)(3)(A) Fire prevention protection. Type I ARCHs shall be in compliance with, but not limited to, the following provisions: Fire escapes, stairways and other exit equipment shall be maintained operational and in good repair and free of obstruction; **FINDINGS** The side door exit was difficult to open due to contact with bottom of door frame.	See Attached	4/7/16
☒	§11-100.1-23 Physical environment. (l)(1) An enclosed dining area within the Type I ARCH shall be provided for residents which shall be apart from sleeping quarters but may be in continuity to the living room area. The following shall prevail: At least one table with twenty nine inches clearance between floor and lower edge shall be provided to allow for those residents using wheelchairs; **FINDINGS** Dining table height for wheelchair resident were 26 inches.	See Attached	11/22/15
☒	§11-100.1-83 Personnel and staffing requirements. (1) In addition to the requirements in subchapter 2 and 3: A registered nurse other than the licensee or primary care giver shall train and monitor primary care givers and substitutes in providing daily personal and specialized care to residents as needed to implement their care plan;	See Attached	11/28/15

PLAN OF CORRECTION

Facility's Name: Hokulaki Senior Living, LLC

Date of Inspection: November 19 and 20, 2015 (Annual)

11-100.1-23 (g)(3)(A)

"Difficult to open side door" was seen by City building inspector who was called by PCG and an engineer of a construction company to make sure that the "difficult to open side door" was not due to settlement of the 11 year-old facility or due to integrity of the structural component of the

building. The door and building was seen again by a construction company after a bout of rainy days. Everyone agreed that " the building structural is fine and there is no danger to residents."

PCG decided to redo said door by having a construction company remove the double door, replaced the frame all around, replaced the bottom jamb of the double door. Replaced hinges; contractor placed the double door a little higher from the threshold. Placed rubber weather stripping to prevent rain water, insects and/or rodents from entering the building. Due to the holidays, construction company was not able to do repair and finish the contracted job until the first week of April, 2016. Work order was not completed until April 7, 2016.

In the future, all doors of the facility will be checked monthly by a maintenance staff and by PCG and designated staff to check all doors monthly during fire drills and will be a part of the list to check during the said monthly drills.

Completion date: April 7, 2016

JK Salaming, RE, PCG

PLAN OF CORRECTION

Facility's Name: Hokulaki Senior Living, LLC

Date of Inspection: November 19 and 20, 2015 (Annual)

11-100.1-23 (l)(1)

This is a table that's very ornate and was acquired 11 years ago, but in a very good shape and form. Because of the ornamentation at the side of the table that's built against the top, it measures 26 inches to the floor. A standard wheelchair will go in under the table without problems. It is when a "transport wheelchair" is used by the resident at the table that will have a little problem because it doesn't go in under the table far enough to be comfortable because of the way the transport wheelchair armrests are built. PCG has placed a 1-1½" block to elevate the table for now. Three inches will make the table too high for every resident that's not on a wheelchair. For now, the resident that's using a wheelchair is using a standard wheelchair with detachable or removable armrests so she can be at the table without problems. It will work even without removing the detachable armrests. A furniture expert is being sought to look at the table so he/she can cut off at least 3 inches of the ornamentation after making sure that the said ornamentation is not part of the weight-bearing capability of the table and will not change the integrity of the structure of the said table.

In the future, PCG will buy a simple and durable table without ornamentation on the lower edge so that it can accommodate all residents in the care home including wheel-chair bound residents. Will purchase a table with the height of 29 inches from the lower edge to the floor on the next acquisition of a dining table for the residents.

Completion date: November 22, 2015

JM Tabaniag, RN, PCC

PLAN OF CORRECTION

Facility's Name: HOKULAKI SENIOR LIVING, LLC
Date of Survey: November 19 and 20, 2015 (Annual)

11-100.1-23(1)(1)

A new 3" block was made and placed under each leg of the table to elevate the table so that the table has now a 29" clearance between the floor and lower edge of the table. Completion date: 10/12/16

Tabaniag, RN, PCC

PLAN OF CORRECTION

Facility's Name: Hokulaki Senior Living, LLC

Date of Inspection: November 19 and 20, 2015 (Annual)

11-100.1-83(1)

SCG #1 was trained by RN, CM on 10/24/15 but SCG forgot to sign the care plan sign-in sheet form. SCG #1 filled out and signed the sheet on 11/28/15 when she came back to work.

PCG and all SCGs on staff will make sure to fill-out and sign and date the care plan sign-in sheet form or any other inservices sign-in sheet forms as soon as the inservice is over. The PCG and RN, CM will check the list and read the names aloud to make sure that all who attended are accounted for and properly registered on the sign-in sheet.

Completion Date: November 28, 2015

SN Labaning, RN, PCG

	FINDINGS SCG #1 – No documentation that the RN Case Manager trained the SCG in providing daily and specialized care to the resident.	See Attached (Page 3) with →	11/28/15
☒	§11-100.1-84 Admission requirements. (a) Licensees of an expanded ARCH shall admit nursing facility level residents as determined and certified by the resident's physician or APRN. **FINDINGS** Resident #1 – Admitted as "adult residential care home" on 10/21/15; however, the RN Case Manager's assessment of 10/23/15 noted the resident required maximum assistance of two (2) persons to transfer; needed to be spoon fed; and required wheelchair for mobility. The level of care changed to intermediate nursing care level on 10/23/15.	See Attached	12/11/15
☒	§11-100.1-88 Case management qualifications and services. (a) Case management services shall be provided for each expanded ARCH resident to plan, locate, coordinate and monitor comprehensive services to meet the individual resident's needs based on a comprehensive assessment. Case management services shall be provided by a registered nurse who: **FINDINGS** Resident #1 – Case management services were not provided at the time of admission.	See Attached	12/11/15
☒	§11-100.1-88 Case management qualifications and services. (c)(5) Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or		

PLAN OF CORRECTION

Facility's Name: Hokulaki Senior Living, LLC

Date of Inspection: November 19 and 20, 2015 (Annual)

11-100.1-84(a)

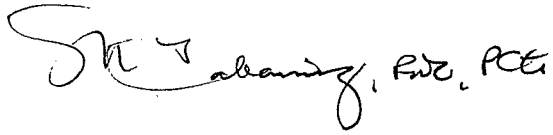
Resident's assessment was done to the best of knowledge as the PCG saw it at the time of admission / readmission to the facility. Resident #1 was discharged from the hospital on a 'Level of Care' that indicated she was an 'ARCH' level signed by the discharging physician so she did not require a Case Manager at that time. As any resident who comes back from the hospital, he or she is still usually very weak due to deconditioning but usually improve after a few days. PCG noted Resident #1 as very slow recovering as she could not drink her honey-thickened fluids thru a straw, etc. and the family were being talked to of resident being admitted to Hospice Care on the second day after re-admission, 10/22/15. Resident #1's PMD and an RN, CM were called by PCG to report present status and changes that were noted. PCG made appointment to bring Resident #1 to her PMD and RN, CM to visit Resident #1 in the care home for reassessment and re-evaluation. Resident #1 was brought to PMD on 10/23/15 for reassessment of present status. Level of Care was changed from Care Home level to ICF by

PMD at that time. RN, CM visited Resident #1 in the care home on 10/23/15 in the afternoon after Resident #1 was already seen by PMD.

Resident #1's Level of Care was already changed to ICF level when RN, CM visited her on 10/23/15. PCG and caregivers don't want any falls to happen, so to prevent falls, residents are usually helped in the beginning more than usual when transferring or in mobility especially when newly admitted/re-admitted from the hospital due to deconditioning. RN, CM wrote what she saw were being done in the care home when she visited on her comprehensive assessment form.

In the future, the PCG will call the aid of the RN, CM to re-evaluate the level of care of the resident on the same day of admission / re-admission to make sure that comprehensive assessment is consistent with the PCG's initial assessment. The assessment admission forms will be carefully filled out with PCG and RN, CM collaborating together in the admission / readmission of residents especially if coming from the hospital to better service the resident in creating the service plan of care or care plan.

Completion Date: December 11, 2015



PLAN OF CORRECTION

Facility's Name: HOKULAKI SENIOR LIVING, LLC
Date of Survey: November 19 and 20, 2015 (Annual)

11-100.1-84(a)

In the future, to ensure that the same deficiency will not happen again:

The CM's comprehensive assessment will be consistent with the PCG's initial assessment. Proper and accurate assessment will provide the true and appropriate plan of care of the resident involved.

PCG will make sure that the Level of Care assessed by the Hospitalist Physician assessing and signing for the Level of Care form reflects the assessment of the PCG as such while still in the hospital and before the resident is discharged. If the Level of Care does not match with present assessment, the physician and discharge planner will be notified at that time, and the Level of Care form will be changed to the more appropriate level of care.

If however, the resident has been assessed as a Care Home Level and starts progressing to a higher level of care, especially in a very short period of time, the PCG will document extensively in the Nurse's Progress Notes of any and all changes that may or will place the resident to a higher level of care. After the assessment is made and it warrants for a higher level of care, the PMD will be notified and resident will be brought to the PMD's office for reassessment so that the level of care will be changed accordingly. A case manager that the resident's family chooses will be called in to assess the newly admitted or readmitted resident. A change of the level of care from care home level to ICF would warrant the need of the case manager to prepare the proper plan of care for the resident to be carried out by the staff. Completion date: 12/11/15

MC Labaniz, RN, PCG

PLAN OF CORRECTION

Facility's Name: Hokulaki Senior Living, LLC

Date of Inspection: November 19 and 20, 2015 (Annual)

11-100.1-88 (a)

Resident's assessment was done to the best of knowledge as the PCG saw it at the time of admission / readmission to the facility. Resident #1 was discharged from the hospital on a 'Level of Care' that indicated she was an 'ARCH' level signed by the discharging physician so she did not require a Case Manager at that time. As any resident who comes back from the hospital, he or she is still usually very weak due to deconditioning but usually improve after a few days. PCG noted Resident #1 as very slow recovering as she could not drink her honey-thickened fluids thru a straw, etc. and the family were being talked to of resident being admitted to Hospice Care on the second day after re-admission, 10/22/15. Resident #1's PMD and an RN, CM were called by PCG to report present status and changes that were noted. PCG made appointment to bring Resident #1 to her PMD and RN, CM to visit Resident #1 in the care home for reassessment and re-evaluation. Resident #1 was brought to PMD on 10/23/15 for reassessment of present status. Level of Care was changed from Care Home level to ICF by

PMD at that time. RN, CM visited Resident #1 in the care home on 10/23/15 in the afternoon after Resident #1 was already seen by PMD.

Resident #1's Level of Care was already changed to ICF level when RN, CM visited her on 10/23/15. PCG and caregivers don't want any falls to happen, so to prevent falls, residents are usually helped in the beginning more than usual when transferring or in mobility especially when newly admitted/re-admitted from the hospital due to deconditioning. RN, CM wrote what she saw were being done in the care home when she visited on her comprehensive assessment form.

In the future, the PCG will call the aid of the RN, CM to re-evaluate the level of care of the resident on the same day of admission / re-admission to make sure that comprehensive assessment is consistent with the PCG's initial assessment. The assessment admission forms will be carefully filled out with PCG and RN, CM collaborating together in the admission / readmission of residents especially if coming from the hospital to better service the resident in creating the service plan of care or care plan.

Completion Date: December 11, 2015

PCG

PLAN OF CORRECTION

Facility's Name: HOKULAKI SENIOR LIVING, LLC
Date of Survey: November 19 and 20, 2015 (Annual)

11-100.1-88(a)

In the future, to ensure that the same deficiency will not happen again:

First, when picking up resident from the hospital for admission/readmission, the PCG will make sure that the Level of Care assessed by the Hospitalist Physician assessing and signing for the Level of Care form reflects the assessment of the PCG as such while still in the hospital and before discharged. If the Level of Care does not match with present assessment, the physician and discharge planner will be notified at that time, and the Level of Care form will be changed to the more appropriate level of care before the resident is discharged from the hospital or facility. This will ensure that a case manager will be hired by resident's family, legal representative, etc. in a timely manner if it warrants the need of one.

If however, the resident has been assessed as a Care Home Level and starts progressing to a higher level of care, the PCG will document extensively of any and all changes that had occurred that may or will place the resident to a higher level of care. After the assessment is made and it warrants for a higher level of care, the PMD will be notified and an appointment will be made as soon as possible to reassess the resident so the PMD can change the level of care more appropriately. A case manager that the resident's family chose will be called to assess the newly admitted or readmitted resident so that the proper plan of care will be prepared for the resident. The CM's comprehensive assessment will be consistent with the PCG's initial assessment.

Completion date: 12/11/15

Tabaniag, RN, PCG

PLAN OF CORRECTION

Facility's Name: Hokulaki Senior Living, LLC

Date of Inspection: November 19 and 20, 2015 (Annual)

11-100.1-88 (c)(5)

ROM exercises were done daily for the resident. There is an entry made on the 'Nurse's Progress notes on 10/22/15 at 0930 that states "Doing passive and active ROMs and exercises." Documentation was started on 11/30/15 to reflect that ROMs were done **daily** as the plan of care suggested to prevent contractures.

Daily exercises and other interventions written on the care plan will be documented on the 'Monthly Summary Progress Report' or on a weekly basis to reflect that therapeutic interventions were done as suggested on the care plan created by the RN, CM. for the individual resident. The PCG and RN, CM will collaborate in that they will check on each other's notes to make sure that documentation is complete for each plan of care made for the resident.

Completion Date: November 30, 2015

JN Tabaniag, RN, PCG

PLAN OF CORRECTION

Facility's Name: HOKULAKI SENIOR LIVING, LLC
Date of Survey: November 19 and 20, 2015 (Annual)

11-100.1-88(c)(5)

In the future, to ensure that the same deficiency will not be repeated again: The therapeutic intervention "ROM once per day x 5 reps" written by CM, RN on the plan of care of the resident which were carried out daily will be documented on the 'Nurse's Progress Notes' on a weekly basis every Saturday of the week reflecting the daily ROMs with 5 reps done with/for resident. It will also be documented on the "Monthly Progress Report" that the plan of care was reviewed weekly and all therapeutic interventions were carried out at the specified MD/CM, RN order such as "ROM once per day x 5 reps" to prevent the resident from getting contractures.
Completion date: 11/30/15

[illegible], RN, PCC

	APRN. The case manager shall: Promote continuity of care and appropriate integration and utilization of services necessary to implement the care plan; **FINDINGS** Resident #1 – The "At Risk for Contractures" care plan included: "ROM once per day x 5 reps." No documentation that ROM exercises performed.	See Attached	11/30/15
☒	§11-100.1-13 Nutrition. (l) Special diets shall be provided for residents only as ordered by their physician or APRN. Only those Type I ARCHs licensed to provide special diets may admit residents requiring such diets. **FINDINGS** Resident #1 – No documentation that diet order "Pureed with nectar-thickened liquids" (10/23/15) was clarified with the physician to include the type of diet.	See Attached	11/21/15
☒	§11-100.1-17 Records and reports. (b)(3) During residence, records shall include: Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs; **FINDINGS** Resident #1 – Progress notes did not reflect that the resident needs to be spoon fed for all meals and snacks.	See Attached	11/21/15
☒	§11-100.1-55 Nutrition and food sanitation. (1)		

PLAN OF CORRECTION

Facility's Name: Hokulaki Senior Living, LLC

Date of Inspection: November 19 and 20, 2015 (Annual)

11-100.1-13 (l)

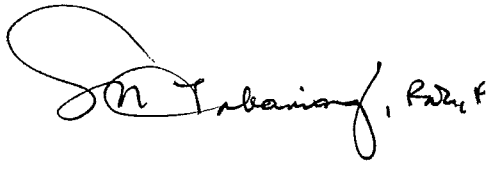
Resident #1 diet **change of liquid consistency** was discussed with PMD before he signed the doctor's order dated 10/23/15 which included the diet: "Pureed with nectar-thickened liquids." Also included with the nectar thickened liquid order is "May use straw to drink nectar-thickened liquids." Resident #1 does not know how to drink her fluids without the use of straw. On admission, she was ordered honey-thickened liquids and had difficulty sucking the fluid up. Tried spoon feeding the liquid but started slurping/sucking like how she would use a straw and there would be more risk for aspiration. Resident #1 has been on pureed diet with nectar-thickened consistency before hospitalization. She has been using straw to drink her fluid years prior to admission to facility per Resident #1's son. After reporting to PMD regarding difficulty of Resident #1drinking the prescribed liquid order, PMD agreed with diet change, signed the order. Since the diet was changed on that day, PMD signed the order, PCG did not see any need for a 'clarification order'. The order was not changed prior to 10/23/15.

In the future, all changes of any order be it medications, diet, etc., there should be a 'clarification order' if there's any changes prior to PMD signing the order.

When the resident has an appointment with her PMD, the resident's current list of meds, diet, and activity written on the 'Physician's Order Form' is also brought with her for review after a report is made to the resident's PMD. After the report and discussion is finished and everyone's question is answered to satisfaction, the list is usually handed to the doctor to read and review. If PMD wants to change anything of the meds, diet or activity, he will change them at this time.

In the future, will ask PMD or APRN if need clarification order for the change in the same situation as above and let them write the diet order themselves. All changes of any order be it medications, diet, etc., there should be a 'clarification order' if there's any changes prior to PMD signing the order.

Completion Date: November 21, 2015



PLAN OF CORRECTION

Facility's Name: HOKULAKI SENIOR LIVING, LLC
Date of Survey: November 19 and 20, 2015 (Annual)

11-100.1-13(l)

The PMD of Resident #1 was called on 11/23/15 to obtain a "Clarification Order' of her present diet which was "Regular Pureed with Nectar-thickened liquids" and not just Pureed with nectar-thickened liquids diet. Explained to PMD that the diet is Regular, and Pureed is the consistency and discussed the need to write a complete diet order which consists of the type or kind of diet, and the consistency or texture of the food in the diet, such as modified-consistency diets.

In the future, to prevent repeating this deficiency, PCG will make sure that all discharge diets from hospitals or facilities or readmission diets from hospitals or facilities, will be written as full, complete diet orders signed by the discharging MD in the hospital or facility, which will include the type of diet, and also the consistency and texture of the food if ordered. (ie. Regular, Pureed with nectar-thickened liquids; Regular NCS, etc.)
Completion date: 11/23/15

Signed Tabaniag, RN, PCG

PLAN OF CORRECTION

Facility's Name: Hokulaki Senior Living, LLC

Date of Inspection: November 19 and 20, 2015 (Annual)

11-100.1-17 (b)(3)

Resident #1 was only spoon fed in the first 2-3 days after readmission from the hospital. She could spoon feed herself but with help at times as she was still weak due to deconditioning from the hospitalization. It was the honey-thickened liquid that was being spoon fed more to her as she had difficulty using the straw to suck the honey-thickened liquids. During assessment, PCG nor RN, CM did not note the need of an OT or PT to be called at that time. Resident has been hospitalized before and had always recovered in a few days.

In the future, PCG and staff caregivers will document on nurse's progress notes when spoon feeding resident and the reason why. RN, CM will be notified of the same and also to include when spoon feeding got started and when it ended or when done occasionally. 11/21/15

JN Tabaniag, RN, PCG

	In addition to the requirements in section 11-100.1-13 the following shall apply to all Type II ARCHs: A registered dietitian shall be utilized to assist in the planning of menus, and provide nutritional assessments for those residents identified to be at nutritional risk or on special diets. All consultations shall be documented; **FINDINGS** Resident #1 – No documentation that Consultant Registered Dietitian was utilized to provide nutritional assessment for resident on a pureed diet and need for complete feeding assistance.	See Attached	11/21/15
☒	§11-100.1-55 Nutrition and food sanitation. (2) In addition to the requirements in section 11-100.1-13 the following shall apply to all Type II ARCHs: All consultant dietitians shall provide special diet training for food preparation staff and ensure staff competency; **FINDINGS** No documentation that Consultant Registered Dietitian provided special diet training for food preparation staff.	See Attached	3/15/16
☒	§11-100.1-88 Case management qualifications and services. (c)(2) Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall: Develop an interim care plan for the expanded ARCH resident within forty eight hours of admission to the expanded ARCH and a care plan within seven days of admission. The care plan shall be based on a comprehensive assessment of the expanded ARCH resident's needs and shall address the	See Attached	11/20/15

	medical, nursing, social, mental, behavioral, recreational, dental, emergency care, nutritional, spiritual, rehabilitative needs of the resident and any other specific need of the resident. This plan shall identify all services to be provided to the expanded ARCH resident and shall include, but not be limited to, treatment and medication orders of the expanded ARCH resident's physician or APRN, measurable goals and outcomes for the expanded ARCH resident; specific procedures for intervention or services required to meet the expanded ARCH resident's needs; and the names of persons required to perform.interventions or services required by the expanded ARCH resident; **FINDINGS** Resident #1 – No care plan was available for resident with dysphagia diagnosis.	See Attached	

PLAN OF CORRECTION

Facility's Name: Hokulaki Senior Living, LLC

Date of Inspection: November 19 and 20, 2015 (Annual)

11-100.1-55 (l) ; 11-100.1-55 (2)

Resident #1 has been documented on the Nurse's Progress Notes that she has been on Pureed Diet for two years now. She was seen and assessed by a Registered Dietitian previously for being on Pureed diet. RD was called and informed about Resident #1's need for complete feeding assistance though she was already spoon feeding herself at that time. Discussed if OT or PT was needed to intervene at that time but decided not to because she was already spoon feeding herself with very minimal assistance. RD was informed again when PCG received the deficiency .

RD inserviced PCG and staff on 3/15/16.

Salaming, RD, P

PLAN OF CORRECTION

Facility's Name: Hokulaki Senior Living, LLC

Date of Inspection: November 19 and 20, 2015 (Annual)

11-100.1-55 (l) ; 11-100.1-55 (2) Continuation

RD had inserviced PCG and staff previously on Special Diet and preparation training in which we all received certificates. Another Special diet inservice on preparation was done on 12/15/15 by RD.

In the future, RD will be called to report and assess residents that need to be seen or consulted on any Special diets and especially to residents being admitted from the hospital. Will continue to consult RD per policy "Referral and Use of Consultant RD." with every resident admission / re-admission to the facility.

RD, PCG

PLAN OF CORRECTION

Facility's Name: Hokulaki Senior Living, LLC

Date of Inspection: November 19 and 20, 2015 (Annual)

11-100.1-88 (c)(2)

Resident #1's plan of care on the dysphagia diagnosis was delivered by RN, CM to DOH Consultant on 11/20/15 during inspection. Care plan on the diagnosis was placed in the chart with the rest of the other care plans, and updated monthly during RN, CM visits.

In the future, PCG and RN, CM will collaborate that all care plans of Resident #1's identified problems or diagnosis are made and in the chart at the specified time written in the Chapter. PCG and RN, CM will be more careful to check if every problem or diagnosis identified has a plan of care with interventions specific to the identified problem/diagnosis. This will be checked at the start of the PCG and staff training after the resident's admission to the facility. 11/20/15

RN, PCG

Licensee's/Administrator's Signature: Myriam R. Tabaniag

Print Name: MYRIAM R. TABANIAG

Date: 3/6/16

Licensee's/Administrator's Signature: M Tabaniag, RE, PCE

Print Name: MYRIAM R. TABANIAG

Date: 10/11/16

Licensee's/Administrator's Signature: Myriam R. Tabaniag

Print Name: MYRIAM R. TABANIAG

Date: 3/6/16