

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RECEIVED 125062	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2017
--	---	--	---

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

(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
4 000	11-94.1 Initial Comments A relicensure survey was conducted by the Hawaii State Agency from June 20, 2017 to June 23, 2017. On June 20, 2017, the resident census was 72.	4 000		
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 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 observation and staff interview, the facility failed to ensure the resident's right to a dignified existence by failing to assist the resident to maintain and enhance a resident's self-worth and self-esteem as the resident was not afforded any assistance during dining for 1 of 27 residents (Resident #38) in the Stage 2 sample. Finding includes: Resident #38 was observed during the lunch dining service on 06/20/17 at 12:21 PM. The resident is blind, but able to grab bowls which his food was placed in. Although there were nurses and nurse aides in the dining room while this	4 115	I. Resident #38 was provided with a napkin and appropriate assistance with dining. Responsible Party: DON and/or designee II. Dining audits were performed to ensure residents are provided with a napkin and provided with appropriate assistance while dining. Responsible Party: DON and/or designee III. Education was provided to nursing and housekeeping staff regarding providing sufficient napkins and assistance to residents during dining. Responsible Party: DON and/or designee IV. Audits of residents being provided with sufficient napkins and assistance during dining will be conducted by DON and/or designee. Results of the audits will be reported to the QA Committee for further follow up if required.	8/4/2017

Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE *7/21/17*

7.24.17 - copy to OLibn

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125062	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/23/2017
--	---	---	---

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

(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
4 115	<p>Continued From page 1</p> <p>resident was eating, his food was spilling out from his mouth as he was hurriedly trying to eat. Thus, a large amount of chow fun noodles spilled out from his mouth onto his left lap. The resident was also using his fingers to dig into his food bowl to scoop the chow fun noodles into his mouth, creating the spillage. In addition, although other residents closer to the kitchen service window had green napkins, Res #38 had no napkin. Staff #2 was asked about Res #38 and she said he was supposed to have a napkin, and did not know why there were no other extra napkins. She then said, "They are still washing, they never deliver yet like the green one like him," and pointed to a resident who had one. There also was no attempt to assist Res #38 by Staff #2 although she was aware of the food spillage. By the time Staff #2 obtained a napkin for the resident at 12:37 PM, the resident had picked at the noodles on his lap area and ate them using his fingers. Thereafter, the resident was seen licking his fingers over and over again which continued for at least another 10 minutes.</p> <p>On 06/22/17 at 8:41 AM, the Director of Nursing (DON) was made aware of the dining observation of Res #38 and that no staff member in the dining room had paid attention to him. She was told of how this resident ended up scooping up the spilled food from his pants to eat it, had no napkin, and thereafter licked his fingers over and over again. The facility failed to provide this resident with the assistance and services in order for him to have eaten his meal in a dignified manner with all the other residents and visitors.</p>	4 115		
4 194	<p>11-94.1-46(k) Pharmaceutical services</p> <p>(k) Drugs shall be stored under proper conditions</p>	4 194	<p>I. No residents were identified as affected by the deficient practice. Responsible Party: DON and/or designee</p>	

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125062	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/23/2017
--	---	---	---

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

HALE KUPUNA HERITAGE HOME, LLC **4297A OMAO ROAD**
KOLOA, HI 96756

(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
4 194	<p>Continued From page 2</p> <p>of sanitation, temperature, light, moisture, ventilation, segregation, and security.</p> <p>This Statute is not met as evidenced by: Based on record review and staff interview the facility failed to store it's refrigerated medications under proper temperature controls.</p> <p>Findings include: On 06/22/2017 at 2:03 PM A review of the facility's records of the temperature logs for the medication refrigerators, 3 total, showed a unit with 4 dates in April (5th, 10th, 11th and 18th) 2017 with the temperature documented at 30 degrees Fahrenheit. On 4/5/2017 maintenance was notified but there was no documentation of the temperature rechecked for this refrigerator. On April 10th, 11th and 18th there is no documentation of the maintenance being notified and no documentation of the refrigerator temperature rechecked. On April 20th this same unit did not document a temperature for this refrigerator. On another unit it was noted that there was no temperature documentation on 5/15/2017 and 06/10/17. Interview of staff #1 at that time confirmed that the temperatures were out of range and confirmed that there were missing temperatures that should have been logged.</p> <p>The facility failed to store it's refrigerated medications under proper temperature controls which could result in injury to the residents.</p>	4 194	<p>II. Medication refrigerators were checked to ensure temperatures were in acceptable temperature range. Responsible Party: DON and/or designee</p> <p>III. Education was provided to nursing staff regarding proper documentation and tracking of medication refrigerator temperatures. Nursing staff was also educated on reporting any out of range temperatures to maintenance. Responsible Party: DON and/or designee</p> <p>IV. Audits of medication refrigerator logs will be conducted by DON or designee. Results of the audits will be reported to the QA Committee for further follow up if required.</p>	8/4/2017
4 249	<p>11-94.1-65(b)(2) Construction requirements</p> <p>(b) The facility shall be fully accessible to, and functional for, physically disabled residents,</p>	4 249	<p>I. Air conditioning bids will be obtained and authorization given to install a system to maintain temperatures between 71 to 81 degrees F. Responsible Party: Administrator and/or designee</p>	

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125062	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/23/2017
--	---	---	---

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

(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
4 249	<p>Continued From page 3</p> <p>personnel, and the public.</p> <p>(2) Temperature and humidity shall be maintained within a normal comfort range;</p> <p>This Statute is not met as evidenced by: Based on observation, resident interviews and a review of the facility's health "provider agreement", the facility failed to ensure comfortable and safe temperature levels for their residents in their facility.</p> <p>Findings include:</p> <p>During a resident interview on 6/20/17 with Res #73 at 11:24 AM, she stated her room temperature "gets so hot. I have a fan, but that's it. It's rough, the summer months. This is how it works, you can buy your own AC and they'll install it for free. I don't have the money to buy an AC (air conditioner)." She stated it got very hot mid-day and asked to check her room then. Another resident, Res #67 stated she could not go into her room during the day to sleep even if she wanted to rest "because it's too hot." Another resident, Res #71 stated there was "heat" in general in the building.</p> <p>An environmental tour to check the facility's resident room temperatures was completed in the three buildings: Ilima, Makalapua and Mokihana, including the resident dining/activity areas on 6/22/17 with the facility's lead maintenance (Staff #3). Staff #3 stated between the use of the laser temperature gun and the digital thermometer, the digital thermometer "is the more ambient temperature." Initial simultaneous readings to check for any significant difference or variance between the two devices was done by Staff #3 for</p>	4 249	<p>II. Areas will be monitored for excessive heat. Additional air circulation and air conditioning will be provided as indicated and practicable within current electrical configuration, during periods of excessively elevated temperature. Responsible Party: Lead Maintenance or Designee</p> <p>III. Education was provided to staff regarding appropriate facility temperature levels. Responsible Party: Administrator and/or designee</p> <p>IV. Audits of facility temperatures will be conducted by Lead Maintenance and/or designee. Results of the audits will be reported to the QA Committee for further follow up if required.</p>	8/4/2017

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125062	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2017
--	---	--	---

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

(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
4 249	<p>Continued From page 4</p> <p>the room temperatures obtained in various rooms of all three buildings. As it was determined there were only tenths of a degree of variance, the facility's ambient room temperatures were taken, read and confirmed using the digital thermometer handled by Staff #3 with direct surveyor observance during the walk through to obtain each building's ambient room temperatures. The following was recorded:</p> <p>Digital thermometer reading of the Ilima building on 6/22/17 at 1:49 PM: Room 7A was 84 degrees Fahrenheit (F). Room 5 was 86 degrees F. During this walk through, Staff #3 stated they did not do routine nor random room temperature checks especially "on really hot summer days." Staff #3 said if they had extra air conditioning (AC) units, they could install them free of charge. Otherwise, he stated the families would have to buy an AC unit. Staff #3 stated for Ilima rooms 9, 13 and 15, the families purchased the AC units, so those room were excluded from the temperature checks.</p> <p>Digital thermometer reading of the Makalapua "Maka" building on 6/22/17 at 2:54 PM: Rooms D4A, D4B and D4C were 86 degrees F. Rooms D5A and D5B were 85 degrees F. Room D2B was 86 degrees F. The main television for the D wing area was 85 degrees F. The Maka C unit showed the main television area to be 83 degrees F. Room C3 was 84 degrees. Room C1 was 85 degrees.</p> <p>Digital thermometer reading of the Mokihana "Moki" building on 6/22/17 at 3:12 PM: the Moki B wing main television area was 84</p>	4 249		

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125062	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2017
--	---	--	---

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

(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
4 249	<p>Continued From page 5</p> <p>degrees F. Room B2A was 82 degrees F. Room B5 was 83 degrees F. Room B3 was 85 degrees F. The Moki rehab area at 3:16 PM was 82 degrees F. The conference room was 84 degrees F.</p> <p>Digital thermometer reading of the Ilima building on 6/22/17 at 3:21 PM: The main Ilima activity area fronting the entrance gate was 84 degrees F. The area by the door to enter the Ilima unit was 87 degrees. The area in front of the Ilima kitchen service window at 3:23 PM was 85 degrees F. Room 18 was 83 degrees F. Room 12 was 84 degrees F.</p> <p>Last, the measurement of the ambient temperature along the driveway outside of the Ilima building measured 87 degrees F on 6/22/17 at 3:28 PM. The facility failed to meet the requirement to provide comfortable and safe temperature levels, such that for facilities initially certified after October 1, 1990 they must maintain a temperature range of 71 to 81 degrees F. None of the room temperatures taken by Staff #3 were found to be at or below 81 degrees F, and verified by this staff.</p>	4 249		