Hawaii Dept. of Health, Office of Health Care Assuranc Amended 10/30/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125013	A. BUILDING: _____ B. WING _____	09/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAUNALANI NURSING AND REHABILITATION	5113 MAUNALANI CIRCLE HONOLULU, HI 96816

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4 000	11-94.1 Initial Comments A recertification survey was conducted at Maunalani Nursing & Rehab Center from August 29, 2017 to September 01, 2017. A census of 97 was noted when the surveyors entered the facility.	4 000		
4 004	11-94.1-2 Definitions As used in this chapter: "Advanced practice registered nurse" or "APRN" means a registered nurse who is licensed pursuant to chapter 457, HRS. This Statute is not met as evidenced by: Based on observation, record review and interview with staff members, the facility failed to ensure the development of a comprehensive care plan for Residents #175 #3131 (R#175) of 24 residents who were included in the Stage 2 review. Findings include: 1)R#175 was admitted on 08/10/2017. On 08/31/2017 7:52 A.M. Resident #175 Observation of Breakfast Watermelon - 25% 1 cup fresh papaya 100% 120 ml Orange juice -100% 120 ml water - 100% 1 cup oatmeal - 100% Egg Mcmuffinn - 25% 240 ml coffee - 25% 08/31/2017 9:31 A.M. R #175 chart review - No	4 004	1. The registered dietitian was immediately contacted to complete the nutrition assessment and care plan for resident #175. The resident did receive proper nutrition during this time and the care plan was completed to reflect resident's nutritional goals and interventions. 2. A review of all residents was completed to ensure timely completion of all nutrition assessments and care plans. 3. The RD will be in-serviced and educated on timeliness of nutrition assessments and care plans to prevent this deficient practice from reoccurring. 4. The RAI manager will monitor all nutrition assessments and care plans to meet compliance with the development of the comprehensive care plan.	9/15/17 9/15/17 10/2/2017 10/2/2017

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Exec. Director — (X6) DATE: 10/30/17

11.6.17 - copy to Glen

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4 004	Continued From page 1 careplan on nutrition noted. Doctor's order reveal that R#175 is on a regular diet, regular texture, regular consistency. Weekly weight on admission. Family may bring outside food and dietician may order supplements. 08/31/2017 11:25:16 A.M. Resident #175 interview with Staff #13 stated there was no nutritional consult and no careplan, no supplements. R#175 is eating and varies from 50-75%. R#175 weight on admission was 111.8 and is at 110 lbs per Staff #13. Our nutritionist is a new gentleman stated Staff #13. We communicate with him by email and by phone. 08/31/2017 2:54 P.M. Interview with staff #110 who stated "she was on arginaid for two weeks and just finished it this week". She gets snacks in between meals. She eats about 50-100% of her meals per day. We assess five days and fourteen days, we see a trend, we a lot for the dietician. She drinks over 1000 ml/ day. We use the BMI between 20 and 22. R#175 has a body mass index (BMI) of less than 22. She was low for the family too. Our charting system will calculate the BMI, even with 3% loss. If we see intake for two days that drops, our system will alert us. Nothing is alerting us so we are just monitoring it at this time". Staff #110 was asked why they don't have a care plan. She did not give this surveyor a reason why they don't have a careplan except that they are monitoring her closely. Findings include: 2) Chart review: 09/01/2017 8:26 A.M. Resident #31 (R#31) is on Plavix 75 mg 1 tablet by mouth one time a day for a history of transient ischemic	4 004		

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4 004	Continued From page 2 attacks. R#31 is at risk for bruising and bleeding due to taking Plavix. Further review of records, revealed side effects of Plavix was not care planned for in record. In conclusion, the facility failed to careplan for a high risk drug which could cause bleeding and bruising. Outcome objectives, interventions and monitoring for Plavix was not noted in the plan of care.	4 004	1. The care plan for Plavix had been in place since 2016 for resident #31. The care plan was updated to include monitoring of bleeding as a side effect of the anti-platelet. 2. All residents on anti-platelets and anti-coagulants will be reviewed and updated to include all potential side effects from high risk medications. 3. Staff will be trained to include all side effects from high risk medications in the care plan within 48 hours. Monthly audits will be conducted by the ADON to ensure compliance and development of care plans.	9/15/17 10/23/2017 10/23/2017
4 130	11-94.1-29(a) Resident abuse, neglect, and misappropriation (a) The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This Statute is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility did not provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well being, in accordance with the comprehensive assessment and plan of care for 3 of 24 residents (Resident #56, #115, #93). Findings include: 1)On 08/30/2017 at 10:04 AM, the MRR on R#93 found that the resident was admitted to hospice on 07/07/17 due to refusing meals and decline in condition. The hospice progress notes docmented that the resident's medication used for gastroesohageal reflux disease (GERD),	4 130	4. All residents on Plavix will be audited monthly to ensure objective interventions and monitoring. A report will be shared with the QAPI team monthly by the ADON.	10/23/2017

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4 130	Continued From page 3 peptic ulcers, erosive esophagitis, and Zollinger-Ellison syndrome be discontinued as recommended by the hospice MD on 07/25/2017. It was noted in the facility's progress notes that the medication was discontinued on 08/01/2017. On 08/31/2017 at 10:46 AM interviewed Staf f#29 and queried why it took 6 days to discontinue the medication for GERD. According to Staff#29, the nursing staff had to wait for the resident's MD to approve the discontinuation of the medication. Written in the facility's communication book on 07/25/2017 was the recommendation that the medication be discontinued. The resident's MD approved the discontinuation of the medication but did not date his comments. Staff #29 was not sure why it took a week to discontinue the medication and was on vacation during the time period. Staff #29 further stated that the hospice nurse usually writes in the communication book as she came to see R#93 at least 1-2 times a week. When Staff#29 returned from vacation the hospice nurse asked her whether the resident's MD approved to discontinue the medication. Staff #29 looked in the communication book and saw that the resident's MD approved to discontinue the medication so it was discontinued on that date 8/01/17. The facility and the hospice staff failed to communicate with each other when changes were indicated for the discontinuation of medications. Findings include: 2)08/29/2017 at 11:30 A.M. Resident #56 (R#56)	4 130	1.) Resident #93's medication for GERD was discontinued on 8/1/17. The hospice company was informed that any recommendations should be verbally discussed with the licensed nurse on duty. 2.) Review of all MD communication binders were done immediately. No other previously missed recommendations were noted from the hospice company. 3.) Staff will be trained on the communication process regarding recommendations by Hospice. A collaboration meeting to discuss the communication process will be held semi-annually. 4.) The unit managers will monitor the communication process by reviewing hospice notes and by communicating with the Hospice nurse when visiting. The hospice company will email any new recommendations to nursing management. If a follow up response is not received within 24-72 hrs, hospice shall follow-up with the facility.	9/05/17 9/05/17 11/30/2017 11/30/2017

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4 130	Continued From page 4 in room, Calling out "hello". Advised him to press his call light but he was unable to press his call light. Resident asked this surveyor to press call light for him. R#56 had call light in his hand but appears too weak to press it. Stated "I'm hungry". This surveyor alerted CNA that he is hungry. 08/29/2017 11:50:07 AM nurse at bedside with medication and to start feeding resident. Res #56 was the last resident to get his tray. 08/31/2017 8:48 A.M. Observation was made of Resident #56 (R#56) in his room. He was dressed in a t-shirt. This surveyor sat with resident. R#56 could not tell me his age. He said his daughter lives in a house. He stated that he was a chemistry teacher. When asked "how was your breakfast?", R#56 stated "Fine, I survived it". This surveyor noted cards from his daughter on wall and signed "Love K___". Also noted two cards at bedside unopened. R#56 confirmed cards were from his daughter. While in his room, there was no TV or radio playing. 08/31/2017 8:57 A.M. R #56 Chart Review: R#56 is on comfort measures only and no transfer to hospital. Careplan "I am able to voice my preferences regarding my daily routine - I have a radio in my room and enjoy listening to the radio. Careplan: I have impaired cognition function and thought processes related dementia - I am not always able to use my call light, please check on me hourly if I need assistance. Keep my bed in lowest position call light within reach. A minimum data set (MDS) which is a resident assessment and care screening tool dated 3/14/17 - how important is it to listen to music you like? - very important.	4 130	1.) The call light was immediately changed to a bulb call light for ease of use when needing staff assistance. 2.) The entire resident population was evaluated to ensure appropriate call bells were provided to the facility's residents. 3.) All residents will be asked to demonstrate call light use. The C.N.A staff will be educated regarding appropriateness of device for each resident. The C.N.A will report to the licensed nurse any difficulties that the resident is encountering to make immediate changes. 4.) A monthly review for call light activation will be conducted by the C.N.A supervisor to assure residents ability to press the call button. A report by the C.N.A supervisor will be shared during the QAPI meeting.	9/1/2017 9/15/17 9/15/17 10/31/2017

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4 130	Continued From page 5 Observation made on: 08/31/2017 11:39 P.M. Resident #56 in his room, awake - saying hello "I'm thirsty" No music playing. Residents served in dining room and R#56 not served yet. No fluids in the room. Resident is not able to use his call bell. 08/31/2017 11:42: P.M. - No tray. Res will talk to you when you go into the room. 08/31/2017 12:02 P.M. - no tray, no music. Asked Staff #89, how do they determine who will get their tray and she stated that they are assigned to residents and the CNA who will feed R#56 is still feeding someone else, so he has to wait. No fluids in the room. 08/31/2017 12:11 P.M. R #56 received his tray from Staff #24, R#56 was the last to receive his tray. Observation made on 08/31/2017 2:53:08 PM R#56 No music playing in room. Observation on 09/01/2017 8:11 A.M. R#56 in his room with lights off. Other residents in dining area eating breakfast. R# 56 still in hospital gown in his room with lights off. No radio playing. Staff nurse was asked why he hasn't eaten - Staff nurse replied "no, the aide will feed him". 09/01/2017 8:24 A.M. Interview with Staff #13 According to Staff #13. Daughter lives on the mainland. She calls once or twice month. He has a son who lives here. We have not seen his son in a long time. What does comfort measures mean in his case? Staff #13 stated "it means we get him up usually after he eats breakfast and after lunch, we put him back to bed. We do not document this. Explained to Staff #13. Observation was made of two unopened letters on his bedside table and the resident has been observed to be the last one to eat on his floor.	4 130	1.) Staff was counseled for not following residents activity of interest (radio). They were instructed to keep radio turned on per his preference. 2.) Care plan was updated to reflect the station and time to have the radio on. The activity manager will reaccess all residents who prefer in room activities. 3.) The C.N.As will be in-serviced to follow all care planned activities. 4.) The activity manager will review the documented daily log to ensure residents are receiving their requested activity.	9/15/17 9/15/17 10/31/17 10/31/17

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4 130	Continued From page 6 Mentioned to Staff #13 that resident has told this surveyor on two occasions that he was hungry and that he was thirsty and he is not able to push his call light although the call light is in his hands. He has been hungry before the time he is scheduled to eat and there is no water in his room. This surveyor did not observe him in a chair during visits to the room during survey dates. Staff #13 stated "Usually the aides get up all the people who are eating in the dining area and they are assigned. Other staff come to help and after the dining is served, then they feed the people in the room. Interview with Staff #1 on 09/01/2017 8:38 A.M. - Activity aides don't have have assigned floor, if he refuses to get up, they will do bedside activities. R#56 will have an assigned aide. In the afternoon, we have a room visit called extra special attention(ESA). As much as possible, we conduct an activity at 10:00 on the 2nd floor. It's not really all the responsibility of the activity aide to open letters. We communicate with the nurses aides too. We focus more on the resident who does not come out of their room and R#56 is on the list for ESA. R#56 was the the last to eat on several observations and would tell surveyor that he was thirsty and that he was hungry. He was not able to use his call bell to alert staff that he was hungry and thirsty and did not have fluids at the bedside. His care plan and MDS preferences state that it is important for R#56 to have the radio playing; however, no observation of radio playing on multiple visits. Lastly, two unopened letters at bedside table that were not opened on observations.	4 130	1.) We have updated resident #56's care plan to eat in the dining room for all meals. Staff will offer fluids to resident on each visit with resident. 2.) Every resident will be offered fluids during staff visits. 3.) Nursing Management will reinforce the practice of offering fluids as part of the facility's "comfort protocol" (pain, positioning, thirst/hunger, tolleting, and placement of personal property,). 4.) The social service department with interview residents whether they are being offered fluids throughout the day. A monthly resident satisfaction report will be produced and submitted to the QAPI committee by the social service department. 1.) Resident #56 will be encouraged to eat all meals in the dining room. 2.) The Charge Nurse will visually check on all residents to ensure meal assistance is provided timely. 3.) All residents will be encouraged to eat out of their room and in the dining room. For those who must eat in their room, assistance will be provided according to the care plan. The Social service staff will monitor compliance to ensure residents are served on a timely basis. 4.) A satisfaction survey will be produced and presented by Social Services during the QAPI monthly meeting.	9/15/2017 10/31/17 10/31/17 10/31/17 9/15/17 9/15/17 10/31/17 10/31/17

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4 130	Continued From page 7 In summary, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. Based on observations, record review, resident and staff interviews, the facility failed to ensure the resident receives the highest practicable physical, mental, and psychological well-being through comprehensive resident assessment and by recognizing and competently and thoroughly addressing the physical, mental or psychosocial needs of the individual. Findings include: 3)Staff interview: 08/31/2017 1:27 PM met with Staff #67 from 3rd floor area to go over Hospice Care. Facility policy for Hospice Care was provided. Noted the Hospice/Nursing Facility Collaboration form provided from Bristol dated 6/6/17. Also saw the Nursing Facility Coordination form. Staff #164 from Bristol Hospice assesses R#115 every Tues and Thurs and Staff #169 comes Tues and Thurs as well. Staff #67 was able to show me the Care Plan from Bristol. When asked if they invite Bristol to their care plan review staff stated that "they have access on the computer to their treatment plans". Later Staff #67 stated that they do care plan review with Hospice staff. Interdisciplinary note from Bristol Hospice dated 6/6/17-9/3/17. Last facility careplan (CP) meeting for R#115 was June 20, 2017 and Staff #164, Staff #167 and Staff #166 from Bristol attended the meeting. 08/31/2017 2:00 PM Staff #67 stated the facility communicates with Bristol by calling Bristol anytime and Bristol also calls them. Staff #67 said that the Bristol staff stops by and talks to the	4 130	1. A psychologist was secured to meet with resident regarding her psychosocial concerns. An evaluation was conducted with several visits, and determined by the psychologist, no further visits were needed. 2. All residents with signs and symptoms of depression will be assessed by the the licensed social worker to determine if the need for psychological consult is warranted. If residents are in need of psychological consult further action will be taken. 3. The social worker will in-service staff on availability of different resources in the facility and the community. The hospice company shall communicate directly to the facility social worker for any mood/ behavior changes. 4. The social worker will communicate with the interdisciplinary team including hospice staff regarding any signs and symptoms of behavioral changes. The social worker will make recommendations as appropriate.	9/15/17 10/31/17 10/31/17 10/31/17

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4 130	Continued From page 8	4 130		

staff about any changes.
Record review: 08/31/2017 1:55 PM of Bristol binder stated that R#115 was accepted to Bristol Hospice for protein malnutrition and underlying Crohns disease. Med record discharge forms from Kuakini medical on 6/6/17 showed that R#115 had intractable vomiting due to distal esophogeal obstruction due to presbysesophagus/aggravated by sucralfate.
08/31/2017 2:18 PM reviewed R#115 med record and there is a progress note from 6/20/17 for last CP review. CP review was done with the following: Nursing, social services, hospice SW and resident family X2. Res did not attend the meeting. R#115 had a Pre-Admission Screening/ Resident Review done on 5/27/17 by Staff #170, PhD who recommended Psychology support to educate, problem solve, goal set. On Mental status exam, it was documented that R#115 is alert, oriented and cognitively intact. Further review of this form showed that "Pt would benefit from psychology follow-up".
08/31/2017 2:57 PM review of res chart shows that an assessment was completed by Staff#165 from Bristol hospice on 6/6/17 with a Care Plan initiated and revisit planned interventions.
Review of res chart from Bristol shows that Staff #164 spoke with Staff #67. Discussion if psychology consult would not be covered by hospice and notified Staff #67 that patient did worry about the cost and if she could speak with patient about whether or not she still wanted to see a psychologist. Asked Staff #67, if she did anything regarding this matter and nothing was documented. Spoke with Staff #134 who stated that the facility has something in place for res who can't afford to see a psychologist--- Nevada Moore Trust Assistance. Staff would help R#115 apply for this and then Staff #34 would either approve or not approve. Staff #67 did not meet

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4 130	Continued From page 9 with the R#115 and nothing more was done with this matter such as filling out the Nevada Moore Trust Assistance sheet to see if the facility would be able to provide psychology appointments for R#115 who cannot afford these appointments.	4 130		
4 153	11-94.1-40(a) Dietary services (a) The food and nutritional needs of the residents shall be met through a nourishing, well-balanced diet in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, and shall be adjusted for age, sex, activity, and disability. (1) At least three meals shall be served daily at regular times with not more than a fourteen hour span between a substantial evening meal and breakfast on the following day; (2) Between meals nourishment that is consistent with the resident's needs shall be offered routinely and shall include a regular schedule of hydration to meet each resident's needs; (3) Appropriate substitution of foods shall be promptly offered to all residents as necessary; (4) Food shall be served in a form consistent with the needs of the resident and the resident's ability to consume it; (5) Food shall be served with appropriate utensils; (6) Residents needing special equipment, implements, or utensils to assist them when	4 153		

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4 153	Continued From page 10 eating shall have the items provided by the facility; and (7) There shall be a sufficient number of competent personnel to fulfill the food and nutrition needs of residents. Paid feeding attendants shall be trained as per the facility's state-approved training protocol. This Statute is not met as evidenced by: Based on direct observation and staff interview, the facility failed to control the time and temperature of the second floor nourishment refrigerator. Findings include: On 09/01/2017 at 9:25 AM the second floor nourishment refrigerator temperature registered at 48 degrees Fahrenheit. Contents inside the refrigerator included resident juice, milk, fruit cups and yogurt. The refrigerator's temperature log was reviewed noting elevated temperatures on the following days: 8/04/17, 46 degrees Fahrenheit; 8/09/17, 44 degrees Fahrenheit; 8/10/17, 44 degrees Fahrenheit; 8/11/17, 46 degrees Fahrenheit; 9/13/17, 42 degrees Fahrenheit; 9/18/17, 46 degrees Fahrenheit. Manual adjustment of the temperature control inside the refrigerator was documented as action taken by staff. At 9:36 AM during a staff interview, staff #10 concurred that the thermometer should read in the green zone between 35 and 41 degrees Fahrenheit. Staff #10 turned the temperature control inside the refrigerator to the coldest setting. The facility failed to store foods in accordance	4 153	1.) The refrigerator has been rechecked to meet the requirements of the correct temperature range. 2.) All refrigerators will be monitored twice a day to ensure proper temperature is met for food storage. A daily log will be kept on the refrigerator and recorded by the dietary staff. If the temperature is not within the acceptable range, staff will recheck in 15 minutes to ensure proper temperature is reached. If appropriate temperature is not reached the dietary supervisor will make arrangements for repair. 3.) All refrigerators will be monitored twice a day, staff will be retrained and educated regarding proper food storage temperatures. Scheduled periodic maintenance will be conducted semi-annually. 4.) Daily monitoring will be conducted for compliance with temperature reading to prevent food borne illness.	9/2/17 9/2/17 9/5/17 9/5/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125013	A. BUILDING: _____ B. WING _____	09/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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4 153	Continued From page 11 with professional standards for food service safety placing the Residents at an increase risk for food borne illness	4 153		