Hawaii Dept. of Health, Office of Health Care Assuranc

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 125059 | A. BUILDING: _____ B. WING _____ | 03/09/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PALOLO CHINESE HOME | 2459 10TH AVENUE HONOLULU, HI 96816 |

| (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 | Initial Comments<br><br>A survey of the facility was completed on 03/09/18. The facility provided a census of 90 residents on the entrance date. | 4 000 | | |
| 4 105 | 11-94.1-22(g) Medical record system<br><br>(g) All entries in a resident's record shall be:<br><br>(1) Accurate and complete;<br><br>(2) Legible and typed or written in black or blue ink;<br><br>(3) Dated;<br><br>(4) Authenticated by signature and title of the individual making the entry; and<br><br>(5) Written completely without the use of abbreviations except for those abbreviations approved by a medical consultant or the medical doctor.<br><br>This Statute is not met as evidenced by:<br>Based on observation, staff interview and record review, the facility failed to maintain accurate medical records on Resident #154 and #53.<br><br>Findings include:<br><br>1) Interview on 3/06/2018 at 10:00 A.M. R#154 stated "there is an epidemic. My daughter and wife cannot come because of an epidemic".<br><br>Record Review on 03/08/2018 at 09:44 A.M. in the progress notes stated "Stayed in bed today for scabies precaution. MD orders written on | 4 105 | 1. On 03/09/2018, the Director of Nursing verified that the resident was showered and the documentation record completed. On 04/06/2018, the certified nurse aide was educated by Director of Nursing to complete ADL documentations accurately and timely. On 04/11/2018, the Director of Nurses validated that the Elimite order was discontinued on 03/06/18 and was not administered on 03/08/18.<br>On 04/09/2018, the Licensed Nurse corrected the "Hemodialysis Interfacility Communication Sheet" for the identified resident #53. The licensed nurses and hemodialysis nurses completed the "Hemodialysis Interfacility Communication Sheet." On 03/09/2018, the Nurse Manager corrected resident #53's care plan/interventions to indicate that the resident had a Permacath.<br>2. On 03/11/2018, the Director of Nursing audited the schedule care monitor in AHT for any missing shower ADL documentation from the certified nurse aides. The missing documentations were completed in a form of late entry by the assigned licensed nurse.<br>On 04/10/2018, the Director of Nurses audited other resident's "Hemodialysis Interfacility Communication Sheet" and validated completion and signatures of Palolo Chinese Home and hemodialysis staff. On 03/21/2018, the Nurse Manager | 04/11/18<br><br>04/10/18 |

Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE ADMINISTRATOR (X6) DATE 4/13/18.



4.13.18 - emailed copy to sw;bn

Hawaii Dept. of Health, Office of Health Care Assuranc

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 125059 | A. BUILDING: ______ B. WING ______ | 03/09/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PALOLO CHINESE HOME | 2459 10TH AVENUE HONOLULU, HI 96816 |

| (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 |
|---|---|---|---|---|
| 4 105 | Continued From page 1<br><br>03/01/2018 for Elmite 5% CN Cream. Apply topically on Thursday evening from neck to toes. Leave on for 12 hours. Shower off in A.M. Repeat once on 03/08/2018. Diagnosis: Scabies<br><br>Interview on 03/08/2018 with Staff #90. Staff #90 was asked how they record that they have showered a resident. A folder located in the shelf above the computer station with a flowsheet of ADL assistance and support was handed to surveyor. On further inquiry, it was missing the necessary documentation that stated that on 03/08/2018, a repeat application of Elmite 5% cream was applied and that it was left on for 12 hours and then showered off in A.M.<br><br>Interview with Staff#88 on 03/09/2018. Staff #88 stated that she did call the staff member who had completed the shower task and that the staff member did not document that she did it but she confirmed that she did do the shower task. It was explained to Staff #88 that because this was a very specific order that would stop the spread of transmission of scabies, documentation should have been demonstrated accurately.<br><br>Policy and Procedure effective 2017 for Outbreak Investigation Protocol states in Step 8 "In some situations, you may implement direct control measures to interrupt transmission or exposure".<br><br>2) On 03/09/18 at 03:00 PM reviewed R#53's care plan (CP) for dialysis and noted that it stated "Monitor AV shunt patency Q shift: Palpate for distal thrill; auscultate for a bruit; evaluate reports of pain, numbing/tingling; note extremity swelling distal to access. Avoid trauma to shunt; e.g., limit activity of extremity. Avoid taking BP or drawing blood samples in shunt extremity. Instruct resident not to sleep on side with shunt or carry | 4 105 | Continue From page 1<br><br>audited all of the assessments and care plans for dialysis residents to ensure that the correct dialysis access was identified and care planned.<br>3. On 04/06/2018, the Director of Nursing and Nurse Manager educated the nursing staff on completion of ADL documentation accurately and promptly; all nursing staff must be completed before their end of shift. Each new hired nursing staff will be educated to complete ADL documentation accurately and promptly. On 04/12/18, a mandatory facility wide in-service was completed to reinforce accurate and prompt documentation.<br>On 03/20/2018, a revised "Hemodialysis Interfacility Communication Sheet" was completed. On 04/10/2018, the licensed nurses were educated by Director of Nursing on the revised "Hemodialysis Interfacility Communication Sheet" and to ensure the all areas in the form is filled out completely by Palolo Chinese Home and hemodialysis nurse. On 04/12/18, a mandatory facility wide in-service was completed to reinforce revised "Hemodialysis Communication Sheet" and the various dialysis access, correct identification and care plan for each type of access.<br>4. On 04/13/2018, the Director of Nursing or designee will audit monthly on completion of accurate and timely ADL documentations. A report will be submitted to QA committee each quarter.<br>On 04/13/2018, the Director of Nursing or designee will audit monthly and validate that "Hemodialysis Interfacility | 04/12/18<br><br>04/13/18 |

Hawaii Dept. of Health, Office of Health Care Assuranc

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 125059 | A. BUILDING: ____ B. WING ____ | 03/09/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PALOLO CHINESE HOME | 2459 10TH AVENUE HONOLULU, HI 96816 |

| (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 |
|---|---|---|---|---|
| 4 105 | Continued From page 2<br><br>packages, books etc. on affected extremity." It was noted that while reviewing R#53's "Hemodialysis Interfacility Communication Sheet" dated from January 4, 2018 to March 3, 2018 the facility nurses documented that R#53 had a "permacath L IJ" and at no time was an AV SHUNT checked off as the vascular access site for this resident. Upon continued review of the Hemodialysis Interfacility Communication Sheets it was noted that there was documentation missing. Of the 26 sheets only 13 noted who was transporting the resident to dialysis, 16 noted the "vascular access site", and only 11 of the 26 communication sheets documented the resident's predialysis weight. At no time did the facility communicate on the 26 Hemodialysis Interfacility Communication Sheets dated from January 4, 2018 to March 3, 2018 the "condition/complaints:" that the resident was in or had. One nurse, on 1/16/18, however did use this box on the form to communicate with the dialysis center inquiring for "copy of recent labs done" and inquired if the "resident need fluid restriction? Yes or no and How much ________ ml/day". 11 of these 26 communication sheets were not signed and dated by the facility nurse and 4 were not signed by the dialysis nurse. The dialysis facility failed to document 15 of the 26 times on resident's "condition/complaints" and failed to check off if the resident's "Discharge" was "stable" or "unstable". While reviewing the resident's record inquired with staff #88 if R#53 has a permacath or an AV shunt and he/she reviewed the resident's record and stated that R#53 has a permacath. Interviewed staff #88 and inquired if "Hemodialysis Interfacility Communication Sheet" dated from January 4, 2018 to March 3, 2018 are required to be completely filled out by facility staff and he/she stated "yes" and concurred that the documentation was incomplete. | 4 105 | Continued From page 2<br><br>Communication Sheet" documentations are completed accurately and promptly by PCH and dialysis staff; the correct identification and care plan of the dialysis access is completed. A report will be submitted to QA committee each quarter. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 125059 | A. BUILDING: ___ B. WING ___ | 03/09/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PALOLO CHINESE HOME | 2459 10TH AVENUE HONOLULU, HI 96816 |

| (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 |
|---|---|---|---|---|
| 4 149 | 11-94.1-39(b) Nursing services<br><br>(b) Nursing services shall include but are not limited to the following:<br><br>(1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty- first day after, or simultaneously, with the initial interdisciplinary care plan conference;<br><br>(2) Written nursing observations and summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, but no less than quarterly; and<br><br>(3) Ongoing evaluation and monitoring of direct care staff to ensure quality resident care is provided.<br><br>This Statute is not met as evidenced by:<br>Based on observation, record review and staff interview, the facility failed to develop and implement a baseline care plan for Resident #153 (R#153) that would provide effective and person-centered care of the resident that includes the minimum healthcare information necessary to properly care for a resident including, but not limited to initial goals based on admission orders.<br><br>Findings include:<br>1) R#153 was admitted with a principal diagnosis | 4 149 | 1. On 03/09/2018, the Nurse Manager completed a comprehensive respiratory care plan for identified resident #53. On 04/06/2018, the licensed nurse was educated by Nurse Manger on the need for a baseline care plan based on the respiratory care of the resident.<br>On 03/09/2018, resident #53's care plan for dialysis was corrected to indicate that the resident had a Permacath. On 03/29/2018, the licensed nurse was educated by Nurse Manager on the different dialysis accesses and the need to assess for and accurately document the resident accesses and the one being used. | 04/06/18 |
| | | | 2. On 03/21/2018, the Nurse Manager completed an audit of all recent admissions' initial 48-hour care plan that each had interventions based on the resident needs with actual treatments. All resident's 48-hour care plan were found to be in compliance.<br>On 03/21/2018, the Nurse Manager completed an audit of all dialysis care plans. All care plans were accurate with appropriate interventions relating to dialysis access. | 03/21/18 |
| | | | 3. On 03/27/2018, the Nurse Manager reviewed and updated "Baseline Care Plan" policy to include conditions and risks affecting the resident's health and safety. On 03/27/2018, the Nurse Manager reviewed and updated "Completion of Care" policy to ensure accurate, timely, completion of care plans. On 03/29/2018, all licensed nurses were in-serviced by Nurse Manager on "Baseline Care Plan" policy. On 04/12/2018, a mandatory facility wide meeting was conducted to reinforce | 04/12/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 125059 | A. BUILDING: ______ B. WING ______ | 03/09/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PALOLO CHINESE HOME | 2459 10TH AVENUE HONOLULU, HI 96816 |

| (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 |
|---|---|---|---|---|
| 4 149 | Continued From page 4<br><br>of Acute Respiratory failure with hypoxia with a secondary diagnosis of Acute respiratory failure with hypoxia and Chronic obstructive pulmonary disease (COPD) exacerbation.<br>Observation on 03/07/18 at 10:39 A.M. revealed resident on 3 liters of O2 with labored breathing. R#153 had just been turned. R#153 demonstrated using accessory muscles, labored breathing and appears anxious.<br>Observation on 03/08/2018 at 07:33 A.M. while R#153 receiving medications from nurse. R#153 still using accessory muscles to breathe. O2 nasal cannula on forehead. Nurse offered to assist her with correct placement of nasal cannula. R#153 initially refusing her medications and correct placement of 02 nasal cannula. R#153 appeared anxious with any activity or movement.<br>Observation on 03/09/2018 at 11:34 A.M. R#153 sleeping and appears comfortable.<br>03/09/2018 at 11:34 A.M. Interview and concurrent record review with S#30 revealed that no baseline care plan in the facility was initiated for respiratory care. Further investigation revealed that hospice care plan had addressed R#153's respiratory status. Hospice care plan was not carried over within 48 hours of admission to promote continuity of care and communication among the nursing staff. R#153's admission diagnosis reflects a primary diagnosis of respiratory failure. R#153's treatments were not reflected in the facilities care plan.<br>In summary, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standard of quality care.<br><br>2) On 03/09/18 at 03:00 PM reviewed R#53's | 4 149 | Continued From page 4<br><br>the process of accurate and timely 48-hour Care Plan.<br>On 03/27/2018, the Nurse Manager educated the nurses on the various dialysis accesses and the need to accurately document on the care plan and "Hemodialysis Inter-Facility Communication Sheet", the resident accesses and the one being used. On 03/29/2018, all licensed nurses were educated by Nurse Manager on various dialysis accesses such as the difference between AV shunt and Permacath and the need to correctly identify and document each.<br>4. On 04/13/2018, the Manager of Clinical Support or designee will audit monthly on the completion of accurate, and timely Baseline Care Plans for all new admissions. A quarterly report will be made to the QA Committee.<br>On 04/13/2018, the Manager of Clinical Support or designee will audit monthly the completion of accurate Comprehensive Care Plans for all residents. A quarterly report will be made to the QA Committee. | 04/13/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 125059 | A. BUILDING: ______ B. WING ______ | 03/09/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PALOLO CHINESE HOME | 2459 10TH AVENUE HONOLULU, HI 96816 |

| (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 |
|---|---|---|---|---|
| 4 149 | Continued From page 5<br>care plan (CP) for dialysis and noted that it stated "Monitor AV shunt patency Qshift: Palpate for distal thrill; acusculate for a bruit; evaluate reports of pain, numbing/tingling; note extremity swelling distal to access. Avoid trauma to shunt; e.g., limit activity of extremity. Avoid taking BP or drawing blood samples in shunt extremity. Instruct resident not to sleep on side with shunt or carry packages, books etc. on affected extremity." It was noted that while reviewing R#53's "Hemodialysis Interfacility Communication Sheet" dated from January 4, 2018 to March 3, 2018 the facility nurses documented that R#53 had a "permacath L IJ" and at no time was an AV SHUNT checked off as the vascular access site for this resident. While reviewing the resident's record inquired with staff #88 if R#53 has a permacath or an AV shunt and he/she reviewed the resident's record and confirmed that R#53 has a permacath. Inquired with staff #85 about information placed on R#53's CP for AV shunt and they admitted that this was a mistake. | 4 149 | | |
| 4 152 | 11-94.1-39(e) Nursing services<br><br>(e) There shall be a policies and procedures manual that is kept current and consistent with current nursing and medical practices and approved by the medical advisor or director and the person responsible for nursing procedures. The policies and procedures shall include but not be limited to:<br><br>(1) Written procedures for personnel to follow in an emergency including:<br><br>(A) Care of the resident;<br><br>(B) Notification of the attending physician | 4 152 | 1. On 03/08/2018, the licensed nurse notified attending physician regarding weight lost for the identified resident. On 04/05/2018 and 04/09/2018, the identified licensed nurses (staff #34 and staff #166) were educated by Director of Nursing on the "Procedure for Notification of Change for Resident" for timely notification of any significant changes.<br>2. On 03/12/2018, the Registered Dietician audited all weight logs for significant weight changes and found no residents with a significant change requiring a notification of the physician.<br>3. On 04/09/2018, all licensed nurses were educated by Director of Nursing on the | 04/09/18<br><br>03/12/18<br><br>04/12/18 |

Hawaii Dept. of Health, Office of Health Care Assuranc

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 125059 | A. BUILDING: ____ B. WING ____ | 03/09/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **PALOLO CHINESE HOME** | **2459 10TH AVENUE HONOLULU, HI 96816** |

| (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 |
|---|---|---|---|---|
| 4 152 | Continued From page 6<br>and other persons responsible for the resident; and<br><br>(C) Arrangements for transportation, hospitalization, or other appropriate services;<br><br>(2) All treatment and care provided relative to the resident's needs and requirements for documentation; and<br><br>(3) Medication or drug administration procedures that clearly define drug administration process, documentation, and authorized<br><br>This Statute is not met as evidenced by:<br>Based on observation, interviews with staff, review of facility's policy and procedures and records, the facility failed to immediately report significant changes in the resident's weight on 3/3/18 and 3/5/18 to the resident's physician per regulation and facility's own policy.<br><br>Findings include:<br>A recertification survey was conducted on 3/6/18 to 3/9/18, and during this time review of the electronic health record reflected that resident whose admitting diagnosis is S/P Bowel Obstruction, and baseline weight is 269.8 lbs, lost seven pounds between 3/2/18 and 3/3/18, six pounds between 3/4/18 and 3/5/18.<br><br>On 3/8/18 at 3:47 p.m. interviewed Staff #34 and asked when do you report a significant weight loss? Staff replied on Monday since the registered dietician does not work on Sunday when weights are taken. Staff #34 was asked what a significant weight loss is and replied three or more pounds. | 4 152 | Continued From page 6<br>updated "Procedure for Notification of Change for Resident" policy for timely notification of physician for any significant changes. Each new hired nurse will be educated on the updated policy. On 04/12/2018, a mandatory facility wide in-service was completed to reinforce updated policy.<br>4. On 04/13/2018, the Director of Nursing or designee will audit monthly on completion of weight logs and timely follow up for residents with significant weight changes. A report will be submitted to QA committee meeting each quarter. | 04/13/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 125059 | A. BUILDING: ________ B. WING ________ | 03/09/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PALOLO CHINESE HOME | 2459 10TH AVENUE HONOLULU, HI 96816 |

| (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 |
|---|---|---|---|---|
| 4 152 | Continued From page 7<br><br>Requested from staff #166 on 3/9/18 at 7:52 a.m. facility's policies and procedures on weighing, assessments and reporting of changes of health status to resident's physician and received the documents at 8:40 a.m.<br><br>The facility's policy and procedure on notification of changes in health status for residents was reviewed and states that the nurse will notify the physician of the changes on the shift the change occurs and document the notification.<br><br>Review of resident's electronic medical record reflected that staff #34 initally notified resident's physician of the weight loss on 3/9/18 at 7:44 a.m., four days after resident had already lost 16.4 pounds, 6.11% of her weight. On 3/9/18 at 11:06 a.m. telephone interview with the physician who confirmed that he was notified of the weight loss on 3/8/18, three days after resident lost 16.4 pounds. | 4 152 | | |
| 4 159 | 11-94.1-41(a) Storage and handling of food<br><br>(a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions.<br><br>(1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and<br><br>(2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. | 4 159 | 1. On 03/13/2018, identified staff (#117) was also educated by Director of Nursing on hand washing and sanitization after touching one's nose and before contact with residents. On 03/14/2018, identified staff (#60) was educated by Director of Nursing on hand washing and sanitizing one's hands before, after and between each contact with residents. Staff #117 was given a written warning by the Director of Nursing on 04/13/2018, and staff #60 was given a verbal warning by the Director of Nursing on 04/11/2018. On 03/08/2018, the 2 identified racks were immediately removed from use. On | 04/11/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 125059 | A. BUILDING: ______ B. WING ______ | 03/09/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PALOLO CHINESE HOME | 2459 10TH AVENUE HONOLULU, HI 96816 |

| (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 |
|---|---|---|---|---|
| 4 159 | Continued From page 8<br><br>This Statute is not met as evidenced by:<br>Based on observation and staff interviews, the facility failed to provide safe food handling practices to prevent the outbreak of foodborne illness.<br><br>Findings include:<br>1) During the dining observation on 03/06/18 at 11:21 A.M., three staff members were handling food trays in the dining area for approximately 12 residents. Staff #60 (S#60) was standing in between two residents and observed to be feeding one resident and prepping the tray for the other resident. No hand sanitization was done between prepping and feeding R#1 and R#2. S#60 then went to food trays in cart and obtained a tray for 3rd resident's food without hand sanitization. S#60 then prepped a straw for Res#4 and then a straw for Res#3. S#60 then disposed of a tray. S#60 obtained a tray for R#5 and took it to R#5. No hand sanitization was done. She then helped set up a napkin for R#5. S#60 then took dishes to dirties and emptied dishes. S#60 handled five resident trays without any hand sanitization. S#60 then pushed the lunch cart to hall and started passing trays out to Res #6 - in Room #1 without hand washing or hand sanitization. S#60 touched the bed controls to set R#6 upright before serving R#6's tray. No hand sanitization was done after set up of R#6's tray. S#60 then passed room #2 or Res #7's tray without hand sanitization. Staff #60 passed Room #3 or R#8's tray without hand sanitization. At this point, surveyor asked S#60 if she was forgetting something? S#60 stated "to warm up?" Surveyor then stated that she has not done hand sanitization since passing trays in dining area and hall, after 8 residents. She then proceeded to wash her hands. | 4 159 | Continued From page 8<br><br>03/20/2018, the Food & Nutrition Service Manager educated staff #122 on the requirement to take, document and ensure the proper temperatures of food before being placed on the tray line. On 03/22/2018, the Food & Nutrition Service Manager educated staff# 122 and 81 on the requirement that food "touched with a towel" should not be served and discarded. Also, staff # 122 and 81 were educated on the requirement to complete the temperatures on the "Tray Line Temperature/Waste Log" each day.<br>2. On 04/06/2018, the Director of Nursing and Nurse Managers educated all nursing staff on hand washing and sanitation after touching one's nose, before, after and between contact with residents. Each new hire staff will be educated on proper hand washing and sanitation.<br>On 03/08/2018, the Food & Nutrition Service Manager checked all kitchen equipment for presence of rust and no other equipment were found. On 03/26/2018, the Food & Nutrition Service Manager supervised and educated the staff on the "Food Temperatures and Logs," "Prevention of Cross Contamination for Utensils, Plates, Pots and Pans," and "HACCP Guidelines Equipment & Utensil Storage" policies and procedures requiring staff to taking temperatures when required; use of the towel and the discarding of contaminated food; completion of the "Tray Line Temperature/Waste Log" each day.<br>3. On 04/09/2018, the Director of Nursing educated the nursing staff on the need to | 04/06/18<br><br>04/12/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 125059 | A. BUILDING: ____ B. WING ____ | 03/09/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PALOLO CHINESE HOME | 2459 10TH AVENUE HONOLULU, HI 96816 |

| (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 |
|---|---|---|---|---|
| 4 159 | Continued From page 9<br><br>2) On 03/08/18 observed lunch trayline at 11:10 AM. Prior to start of trayline food distribution the food temperatures were taken and recorded. As the trayline continued it was found that 2 food items (fish and rice) were replenished on the trayline and their temperatures were not taken. It was also observed that as staff #122 replenished the rice they dropped part of a dirty towel, which had been used earlier to wipe the counter, on the newly placed rice. Staff#122 was directed to throw out the rice by staff #81. As staff #122 replaced the rice again it was observed that they dropped a corner of part of the dirty towel onto the newly placed rice. After lunch trayline observation reviewed the February 2018 Tray Line Temperature /Waste Log and found that the documentation was incomplete. Interviewed staff #122, who was working on 02/05/18, and had recorded some of the temperatures. Inquired why there were missing temperatures during lunch and they stated "we were short staffed" and then stated "but that is not an excuse". Staff #81 confirmed that all temperatures were to have been documented for food cooked that day for lunch.<br><br>On 03/08/18, after observing trayline food distrubition, observed that the kitchen had a large rolling dish storing rack that had "rust", as confirmed by staff #105, throughout on the parts that dishes rested on to dry. The kitchen also had a large rolling rack that stored metal storage containers and lids and again "rust" was confirmed to be on the rack by staff #105. Rust was also observed and confirmed by staff #105 on the cutting board storage racks.<br><br>3) During the dining observation on 03/06/18 at 12:11 PM Staff #117 was observed to rub his nose with his right hand then pick up the | 4 159 | Continued From page 9<br><br>wash/sanitize hands after touching one's nose, before, after and between contact with each resident per "Handwashing" policy and procedure. On 04/12/2018, a mandatory facility wide in-service was completed to educate staff on the "Handwashing" policy and procedure.<br>On 04/02/2018, the Food & Nutrition Service Manager educated the staff on the "Food Temperatures and Logs," "Prevention of Cross Contamination for Utensils, Plates, Pots and Pans," and "HACCP Guidelines Equipment & Utensil Storage" policies and procedures requiring staff to taking temperatures when required; use of the towel and the discarding of contaminated food; completion of the "Tray Line Temperature/Waste Log" each day. On 04/12/2018, a mandatory facility wide in-service was completed to reinforce proper food temperature, food safety, and free of rust.<br>4. On 04/13/2018, the Director of Nursing or designee will audit monthly for compliance with handwashing policy and procedure. A report will be submitted to QA Committee each quarter. On 04/13/2018, the Food & Nutrition Service Manager or designee will conduct monthly audit of staff and equipment to ensure compliance with food temperature logs, food safety and rust-free equipment. A report will be submitted to QA Committee each quarter. | 04/13/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 125059 | A. BUILDING: ______ B. WING ______ | 03/09/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PALOLO CHINESE HOME | 2459 10TH AVENUE HONOLULU, HI 96816 |

| (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 |
|---|---|---|---|---|
| 4 159 | Continued From page 10<br>resident's drink cup to give the resident a sip of the liquid. Staff #117 then picked up residents spoon and fork with the right hand to give the resident a bite of food. Staff #117 did not sanitize hands after rubbing his nose before assisting the resident with the meal.<br><br>On 3/08/18 at 9:35 A.M. an interview was conducted with Staff #19 who provided the following inservice training documents for staff #117: Nurse Aide clinical skill competency; evaluation form; remedial education; and plan of correction. Upon review of the documents the following comments were revealed: "A lot of tries, staff #117 miss to change gloves in between care, also forgets to use the sani-hands in between care, and needs to be reminded all the time".<br>Review of the remedial education plan of correction dated 12/15/17 stated that Staff #177 needs improvement on infection control and that 1:1 education was done on the importance of proper hand hygiene and gloving to prevent the spread of infection. Staff #117 will be observed for consistency with sanitizing/ washing his hands properly. For example, after he touches anything dirty, between residents, before/ after changing gloves. Staff #117 will be re-evaluated on 3/15/18.<br><br>The Hand hygiene policy was reviewed and states that hands must be washed thoroughly with soap and water or an alcohol based antiseptic handrubs when visibly soiled and before and after resident contact. | 4 159 | | |
| 4 197 | 11-94.1-46(n) Pharmaceutical services<br><br>(n) Discontinued and outdated prescriptions and | 4 197 | 1. On 03/09/2018, the expired medication was discarded. On 03/14/18, the licensed nurse was educated by Director of Nursing to discard expired medications. | 03/14/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 125059 | A. BUILDING: ______ B. WING ______ | 03/09/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PALOLO CHINESE HOME | 2459 10TH AVENUE HONOLULU, HI 96816 |

| (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 |
|---|---|---|---|---|
| 4 197 | Continued From page 11 | 4 197 | Continued From page 11 | |
| | containers with worn, illegible, or missing labels shall be disposed of according to facility policy. | | 2. On 03/09/2018, the Director of Nursing and Nurse Managers checked all medication carts and storage for expired medications and none were noted. | 03/09/18 |
| | This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to label in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the appropriate expiration date when applicable. | | 3. On 04/04/18, the licensed nurses were educated by Director of Nursing to remove and discard expired medications at all times. Each new hired licensed nurse will be educated to ensure medication carts and storage are free from expired medications and to discard expired medications. On 04/12/2018, a mandatory facility wide in-service was completed for "Storage of Medication" policy on "appropriate expiration date" of medications. | 04/12/18 |
| | Findings include On 03/09/18 at 10:17 A.M. two medication carts and two med storage rooms were reviewed for proper labeling and storage. Review of the medication cart on Lehua Unit with staff #19 revealed an expired date of 02/28/18 for Warfarin 1 mg tab by mouth. Staff#19 confirmed that the medication expired on 02/28/2018 and should have been discarded. | | 4. 04/13/2018, the Director of Nursing or designee will audit monthly that there are no expired medications in medication carts and storage. A report will be submitted to QA committee meeting each quarter. | 04/13/18 |
| 4 203 | 11-94.1-53(a) Infection control | 4 203 | 1. On 03/09/2018, the identified resident was assessed for signs/symptoms of infections to GT site. On 03/14/2018, the identified licensed nurse was educated by Director of Nursing on the importance of "perform hand hygiene after removing gloves". | 03/14/18 |
| | (a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste. | | 2. On 03/12/2018, the Director of Nursing educated each nurse on the proper hand hygiene during dressing changes/changing gloves and completed a competency checklist on all of the licensed nurses during dressing changes and validated that each was performing hand hygiene after each glove change. | 03/12/18 |
| | This Statute is not met as evidenced by: Based on observation, staff interview and review of facility policy staff #154 failed to follow proper hand hygiene procedures while performing a G-tube dressing change for resident (R) #69. | | 3. On 03/27/18, the Director of Nursing | 04/12/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 125059 | A. BUILDING: ______<br>B. WING ______ | 03/09/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PALOLO CHINESE HOME | 2459 10TH AVENUE<br>HONOLULU, HI 96816 |

| (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 |
|---|---|---|---|---|
| 4 203 | Continued From page 12<br><br>Findings include:<br><br>On 3/8/17, in the afternoon, went to observe staff #154 perform a g-tube dressing change with R#69 . Nurse changed gloves three times during the dressing change and confirmed that he/she did not do hand hygiene with each glove change, before putting on clean gloves. Met with staff #88 afterwards who confirmed that staff are to do proper hand hygiene while providing care for residents.<br><br>Review of facility's "Standard Precaution/Use of PPE" policy found under "PROCEDURE: 1. Perform Hand Hygiene f. After removing gloves." | 4 203 | Continued From page 12<br>in-serviced all license nurses on the proper hand hygiene during dressing changes and glove changes per "Handwashing" policy and procedure. On 04/04/2018, all licensed nurses were re-educated to wash their hands before donning gloves and between changes of gloves when moving from one procedure to another. Each new hired licensed nurse will be educated to wash their hands before donning gloves and between changes of gloves when performing a procedure and moving from one procedure/step to the next. On 04/12/2018, a mandatory facility wide in-service was completed to reinforce infection control and policies and procedures for proper glove changing during procedures.<br>4. On 04/13/2018, the Director of Nursing or designee will audit monthly that Licensed Nurses are sanitizing/washing their hands, per policy, during dressing changes; in the beginning and between changes of gloves when performing a procedure. A report will be submitted to QA committee meeting each quarter. | 04/13/18 |
| 4 216 | 11-94.1-55(c) Housekeeping<br><br>(c) Floors, sinks, toilets, and showers in resident areas shall be cleaned at least once daily.<br><br>This Statute is not met as evidenced by:<br>Based on observation and staff interview the facility failed to provide a clean and safe environment in 2 resident shower rooms.<br><br>Findings include:<br><br>On 03/06/18, while doing the initial tour on Weinberg Hall 1, observed that room 114's bathroom handheld shower head, the wall and floor tile had a black/gray substance.<br><br>On 03/09/18 at 10:44 AM interviewed staff #110 and #130 who stated that they use cleaner 456 from ECO lab to clean the shower rooms. During that time it was noted that the hand held shower | 4 216 | | |

Hawaii Dept. of Health, Office of Health Care Assuranc

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 125059 | A. BUILDING: ______ B. WING ______ | 03/09/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PALOLO CHINESE HOME | 2459 10TH AVENUE HONOLULU, HI 96816 |

| (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 |
|---|---|---|---|---|
| 4 203 | Continued From page 12<br><br>Findings include:<br><br>On 3/8/17, in the afternoon, went to observe staff #154 perform a g-tube dressing change with R#69 . Nurse changed gloves three times during the dressing change and confirmed that he/she did not do hand hygiene with each glove change, before putting on clean gloves. Met with staff #88 afterwards who confirmed that staff are to do proper hand hygiene while providing care for residents.<br><br>Review of facility's "Standard Precaution/Use of PPE" policy found under "PROCEDURE: 1. Perform Hand Hygiene f. After removing gloves." | 4 203 | | |
| 4 216 | 11-94.1-55(c) Housekeeping<br><br>(c) Floors, sinks, toilets, and showers in resident areas shall be cleaned at least once daily.<br><br>This Statute is not met as evidenced by:<br>Based on observation and staff interview the facility failed to provide a clean and safe environment in 2 resident shower rooms.<br><br>Findings include:<br><br>On 03/06/18, while doing the initial tour on Weinberg Hall 1, observed that room 114's bathroom handheld shower head, the wall and floor tile had a black/gray substance.<br><br>On 03/09/18 at 10:44 AM interviewed staff #110 and #130 who stated that they use cleaner 456 from ECO lab to clean the shower rooms. During that time it was noted that the hand held shower | 4 216 | 1. On 03/09/2018, the room 114's hand-held shower head, and shower wall/floor tile; room 123's hand-held shower head were cleaned and disinfected. Room 123's drain was polished and one rusted screw was replaced. The identified staff #110 and staff #130 was educated by Environmental Service Manger on proper cleaning of shower stalls.<br><br>2. On 03/11/2018, all hand-held shower heads, shower walls/floor tiles and metal shower drain grates were assessed for black, gray, orange substances and cleaned, disinfected, and replaced as necessary. | 03/09/18<br><br>03/11/18 |

Hawaii Dept. of Health, Office of Health Care Assuranc

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 125059 | A. BUILDING: ______<br>B. WING ______ | 03/09/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PALOLO CHINESE HOME | 2459 10TH AVENUE<br>HONOLULU, HI 96816 |

| (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 |
|---|---|---|---|---|
| 4 216 | Continued From page 13<br>head and tile in shower room 114 continued to have the black substance on them.<br><br>On 03/09/18 at 11:04 AM requested that staff #105 escort us as we toured the Weinberg Hall 1 resident and shower rooms. While in room 123 it was noted that there was black substance on the hand held shower head and the shower drain had what appeared to be a dark orange colored substance which staff #105 stated was "rust". Staff #105 concurred that the wall and floor tile, hand held shower head and drain should be kept clean. | 4 216 | Continued From page 13<br><br>3. On 03/13/2018, Environmental Service Manager updated the “7 Step Room Cleaning Procedures” policies to include rust, shower heads, and wall tile grouts. On 03/20/2018, training was completed with all Environmental Services staff and housekeepers on proper inspection, cleaning and disinfection of all resident room equipment and fixtures. On 04/12/2018, a mandatory facility wide meeting was completed with all staff/Nursing to reinforce updates to cleaning policies and procedures, and to provide a “clean and safe environment” in all areas.<br>4. On 04/13/2018, the Environmental Service Manager or designee will conduct monthly audits to verify compliance with proper cleaning procedures. Results will be reported and reviewed at each quarterly QA meetings. | 04/12/18<br><br>04/13/18 |