Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125062	A. BUILDING: ______ B. WING ______	09/07/2018

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

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4 000	Initial Comments A re-licensure survey was conducted from 09/04/18 to 09/07/18. The facility census included 65 residents.	4 000		
4 118	11-94.1-27(7) 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: (7) The right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive; ☐ This Statute is not met as evidenced by: Based on medical record reviews and interviews, the facility failed to ensure that 2 residents out of 27 residents were informed of the right to accept or refuse the right to formulate an advanced directive. Findings: 1. Resident # 37 was interviewed 09/06/2018 at 11:00 AM and stated no one from the facility had spoken to him about advanced directives. His Brief Interview for mental Status Score (BIMS) completed in June 2018 was 15/15 under Section C - Cognitive Patterns in the Minimum Data Set assessment (MDS). during an interview with the Social Worker on 09/06/2018, an unsigned and	4 118	1. Social Services Director visited with resident #37 on 9/6/18 and he confirmed that the Advanced Directive filled out on 2/13/18 was still accurate with his wishes. This document was completely executed and signed on 10/1/18. Social Services Director visited with resident #58 on 9/6/18 regarding his right to accept or refuse the right to formulate an advanced directive. Resident #58 elected to refuse to formulate an advanced directive and this decision was documented in the medical record. 2. Audited to determine if the opportunity to accept or refuse the right to formulate an advanced directive was given.	10/22/18

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/27/18

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4 118	Continued From page 1 unotarized advanced directive was shown. The date on this document was 02/13/2018. There was no copy in the medical record and no documentation in the medical record to support this had been discussed with Resident #37. 2. A medical record review was conducted for Resident #58. Not advanced directive was found and their was no documentation in the medical record to confirm that the information regarding advanced directives had been given to Resident #58. The Social Worker was interviewed on 09/06/2018 and they were unable to find any documentation in the medical record in regards to Resident # 58 being provided with information on advanced directives, and given the opportunity to either refuse or pursue an advanced directive.	4 118	Appropriate follow up initiated based on audit results. 3. Education was provided to the IDT team regarding the right to accept or refuse the right to formulate an advanced directive. 4. Per the RAI schedule resident advanced directive choices will be monitored by the IDT team. Administrator and/or designee will review to ensure appropriate follow up. Results of review will be reported to the QA Committee for further follow up if required. Responsible Party: Administrator and/or designee	
4 203	11-94.1-53(a) Infection control (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. This Statute is not met as evidenced by: Based on observation, staff interview and facility policy review, the facility failed to maintain appropriate infection control technique when performing a dressing change for Resident 37 (R37). Findings include: A Licensed Nurse (LN71) did a dressing change for R37 on the morning of 9/7/18 at 9:48 AM.	4 203	1. The identified staff member was immediately in-serviced upon notification of deficient practice. Responsible party: DON and/or designee. 2. Audits of appropriate infection control techniques during dressing changes were completed to ensure no other residents were affected by deficient practice. Appropriate follow up initiated based on audit results.	10/22/18

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4 203	Continued From page 2 LN71 was observed: Donned clean gloves; Removed R37's sock from his left foot; Used alcohol pads to clean off old tape adhesive from his left foot; Removed the soiled bandage from the wound on his left foot; and Placed clean gauze directly on the bedside table (which wasn't sanitized). With the same soiled gloves, LN71 continued: Poured normal saline on "clean" gauze (which was set directly on the bedside table) and wiped the wound; Placed ointment on wound; Placed a clean corn bandage around wound; Covered with "clean" gauze (which was set directly on the bedside table); Removed gloves, no hand sanitizing; Donned clean gloves; Placed sock back on his left foot. An interview of LN71 at 9:59 AM revealed her understanding that she should have removed her contaminated gloves and hand sanitized before donning clean gloves and proceeding with the clean supplies. A review of the facility policy for "Using Gloves" on the morning of 9/7/18 at 11:00 AM found staff should remove contaminated gloves, perform hand hygiene, and don clean gloves before proceeding with a clean procedure.	4 203	3. Education on appropriate infection control techniques was provided to nursing staff that perform wound care. 4. Routine audits of appropriate infection control techniques during dressing changes will be conducted by DON and/or designee. Results of the audits will be reported to the QA Committee for further follow up as indicated. Responsible party: DON and/or designee	
4 210	11-94.1-54(a) Sanitation (a) The facility shall be in compliance with all applicable laws of the State and rules of the department relating to sanitation. This Statute is not met as evidenced by: Based on observation and interview with staff members, the facility failed to store foods at acceptable parameters and staff member	4 210	1. Upon notification of the deficient practice, a hair restraint was provided and used by staff member. At this same time,	10/22/18

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4 210	Continued From page 3 preparing food was not wearing a hair restraint. Findings include: On 09/05/18 at 10:25 AM observed Staff Member 10 (SM10) grilling hot dogs. The facility put up a tent and set up a grill outside for an activity. The staff member reported the grilling of hot dogs was a cooking activity for the residents; however, due to the weather the residents would not be coming out. Further observation found two packs of unheated hot dogs on a cart. The staff member was observed to pick up a pack of unheated hot dogs from the table to place in a metal pan. When the pack was lifted, liquid was dripping from the empty plastic wrapper that was still attached. The staff member placed the remaining hot dogs in one of three covered metal pans. The second pan contained hot dog buns and the third pan contained grilled hot dogs. The three pans were placed on the table. The staff member grilling the hot dogs was not wearing a hair restraint. An interview was conducted with the Assistant Food Service Director (AFSD). The observation of the staff member was shared with the AFSD. The AFSD reported the hot dog grilling is an activity for the residents. The activities department will request for supplies and the kitchen will prepare the supplies then the activities staff will pick up the supplies. The AFSD confirmed the staff member is required to wear a hair restraint while preparing food and the unheated hot dogs should be placed on an ice bath. The AFSD prepared a metal tray with ice and went to the office to obtain hair restraints for the staff member. At 10:35 AM, the AFSD went to the tent with a	4 210	cooked and uncooked hot dogs were stored at appropriate temperatures. No residents were affected by the deficient practice. 2. Audited food related activities to ensure no deficient practices. Appropriate follow up initiated based on audit results. 3. Education was provided to Activities and Dietary staff regarding proper hair restraint use and appropriate food storage temperatures and techniques. 4. Routine audits of hair restraint use and appropriate food storage temperatures and techniques during food activities will be conducted by Administrator and/or designee. Results of the audits will be reported to the QA Committee for further follow up as indicated. Responsible Party: Administrator and/or designee	

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4 210	Continued From page 4 hair restraint for the staff member and a metal pan with ice to store the unheated hot dogs. A second observation found the unheated hot dogs on an ice bath and Staff Member 11 was placing the grilled hot dogs in a metal pan that was stored on the hot grill. The AFSD reported the temperature for the unheated hot dogs was 42 degrees.	4 210		
4 213	11-94.1-54(d) Sanitation (d) Every facility shall maintain an effective pest control program so that the facility is free of pests and rodents. This Statute is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain an effective pest control program to control the fly (insect) population. Findings include: 1. Observation of the lunch meal on the morning of 9/4/18 at approximately 11:45 AM found several flies around the dining room on the Ilima unit. The flies were observed landing on various surfaces during the lunch meal. Although the flies were constantly around, there were increased numbers of flies during meal times. Some of the residents were not capable to moving their limbs independently to fan the flies away. Other residents were unable to react quickly enough to fan the flies away before they landed on their food or their bodies. Several flies were observed in the Mokihana unit while returning to the conference room. In the conference room, surveyors observed multiple flies. One fly would get swatted then two more	4 213	1. A reevaluation of the facility was completed by the contracted pest control company, with recommendations made to the administrator. Professional recommendations initiated. 2. Preventative maintenance program reviewed and revised to ensure minimization of flies within facility. 3. Education was provided to staff regarding properly reporting any fly problems within the facility to ensure appropriate follow up occurs. 4. Audits of dining and kitchen areas will be done by Administrator and/or designee to monitor for flies. Results of the audits will be reported to the QA Committee for further follow up if required. Responsible Party: Administrator and/or designee	10/22/18

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4 213	Continued From page 5	4 213		

would appear. During the survey period from 9/4/18 to 9/7/18, the conference room would have at least two flies present throughout each day.

A meeting with three Resident Council members (R7, R18, R61) on the morning of 9/6/18 at 11:00 AM was conducted in the Activities area outside the Ilima area. There were multiple flies swarming around. The residents were asked about the flies. All three residents replied they recognize the facility has a lot of flies. The three residents stated it was difficult for the facility to manage since the Activities area is in an outdoor area.

An interview of the Maintenance Supervisor on the afternoon of 9/5/18 at 3:40 PM revealed the facility kept a log to indicate where pests were found. The Maintenance Supervisor stated the facility had a contract with an exterminator who came monthly. The facility provided information in the log book to let the exterminator know where the problem areas were.

2. On 09/05/18 at 10:25 AM observation found a fly in the kitchen. Subsequent observation was done on the morning of 09/06/18. Observation found three flies in the kitchen. Concurrent observation and interview was conducted with Staff Member 11 (SM11). The staff member acknowledged there were flies in the kitchen and reported the facility has pest control prevention; however, it is difficult to control the flies as there are staff members and visitors that go in and out of the unit. There is a blower at the entrance to the unit that houses the kitchen. The staff member also reported there is a blower at the kitchen's back door. The staff member also reported there is a device that has blue lights to attract the flies and once the flies get dizzy they

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4 213	Continued From page 6 will become trapped on a sticky strip at the bottom of the box. During our conversation observed three flies enter the blue light box and only one fly was trapped in the box. 3. During a lunch meal observation of the Makalapua Assembly Area, on 09/05/18 @ 11:45 AM, several flies were noted to be flying while the residents were eating lunch. One fly landed on a resident's eating surface, and the resident was not aware. Another fly landed on the resident's head and didn't seem to have noticed.	4 213		