STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125013	A. BUILDING: _____ B. WING _____	09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAUNALANI NURSING AND REHABILITATION CENTE	5113 MAUNALANI CIRCLE 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 A re-licensure survey was conducted from 09/24/18 to 09/27/18. At the time of the entrance conference, the reported resident census was 90.	4 000		
4 099	11-94.1-22(a) Medical record system (a) The facility shall have available sufficient appropriately qualified staff and necessary supporting personnel to facilitate the accurate processing, auditing and analysis, indexing, filing, and prompt retrieval of records, record data, and resident health information. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure the required Minimum Data Set (MDS) assessments were encoded and transmitted for two of 36 sampled residents (R4 and R140). This deficient practice had the potential to affect payment, quality measure monitoring, and the facility's ability to better monitor the residents' progress over time. Findings include: 1. Per the 09/25/18 electronic medical record (EMR) "Profile," the facility admitted R4 on 11/14/16. R4's 08/25/18 quarterly "Minimum Data Set (MDS)," an assessment tool completed by the facility staff used to identify resident care problems and assist with care planning, was signed as completed on 09/10/18 per section Z0500B. Per the EMR "MDS" tab, the status of the quarterly MDS was "Export Ready." On 09/25/18 at 3:26 PM, the MDS Coordinator	4 099	1.) The MDS that was due on 9/24/18 and 9/27/18 were submitted electronically the following day on 9/28/18. 2.)The MDS assessments were reviewed, and no other late submissions were identified. 3.)The MDS Manager and MDS Nurse will check the due date on the MDS daily and electronically submit the data according to the RAI regulations. 4.)The MDS manager will monitor all completed and transmitted MDS and present the report to the PIP committee.	10/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125013	A. BUILDING: _____ B. WING _____	09/27/2018

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

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4 099	Continued From page 1	4 099		

(MDSC) stated R4's quarterly assessment should have been submitted within 14 days of completion, but it had not yet been submitted. The MDSC stated, "it is late."

2. Per the 09/25/18 EMR "Profile," the facility admitted R140 on 08/21/18.

R140's 08/28/18 admission MDS assessment was signed as completed on 09/04/18. Per the EMR "MDS" tab, the status of the admission MDS was "Export Ready." Per section V0200C2, the care plan completion date was 09/04/18.

On 09/25/18 at 3:26 PM, the MDSC stated R140's admission assessment should have been submitted within 14 days of completion, but it had not yet been submitted. The MDSC stated, "it is late."

On 09/25/18 at 3:26 PM, the MDSC stated, "From the completion date, we have 14 days to submit the assessment." She added that assessments with an "Export Ready" status have not yet been submitted. She stated the assessments were held for quality assurance, but they should have been submitted within the required timeframes.

On 09/26/18 at 1:48 PM, the MDS Manager stated the assessments should have been submitted within 14 days of the completion dates, but sometimes some were missed.

Per the October 2017 Centers for Medicare and Medicaid Services 'Resident Assessment Instrument (RAI) Version 3.0 Manual,' "All Medicare and/or Medicaid-certified nursing homes and swing beds, or agents of those facilities, must transmit required MDS data records to CMS' Quality Improvement and

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	125013	A. BUILDING: _____ B. WING _____	09/27/2018

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

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4 099	Continued From page 2 Evaluation System (QIES) Assessment Submission and Processing (ASAP) system . . . Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date ([section] V0200C2 + 14 days). All other MDS assessments must be submitted within 14 days of the MDS Completion Date ([section] Z0500B + 14 days)." The facility's 05/11/18 policy addressing MDS completion documented, "Electronic transmission of MDS shall be in accordance with current OBRA (Omnibus Budget Reconciliation Act) regulations."	4 099		
4 120	1-94.1-27(9) 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: (9) The right to names, addresses, and telephone numbers of pertinent resident advocacy groups; This Statute is not met as evidenced by: Based on interview and record review the facility failed to orally provide the location of the contact information for the long-term care ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq). Findings include: During a resident council interview on 09/26/18 at	4 120	1.) The resident Council meeting was held on 9/28/18 and the following was discussed: a. All the locations of the prior year survey results. b. The name and contact information of the Ombudsman. c. The Dept. of Health/ Medicaid contact information.	10/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125013	A. BUILDING: _____ B. WING _____	09/27/2018

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

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4 120	Continued From page 3 10:11 AM with the resident council president and the following residents (R)31, 85, 59, and 9 answered no when asked if they knew the location of the contact information for the state long term care ombudsman. An interview was conducted with the community life director on 09/26/18 at 10:45 AM who showed the location of the state ombudsman contact information posted on the third floor dining room bulletin board and stated that the volunteer ombudsmen comes to the monthly resident council meetings and answers questions for the residents. The resident council meeting minutes dated 09/08/17 to 09/07/17 were reviewed. No documentation was found to indicate that the contact information for the state long term care ombudsman was discussed or provided to any of the residents during the resident council meetings. Based on interview and record review the facility failed to post the results of the most recent survey of the facility in a place readily accessible to residents, family members, and the residents' legal representatives. Findings include: During a resident council interview on 09/26/18 at 10:11 AM with the resident council president and the following residents (R)31, 85, 59, and 9 answered no when asked if they knew the location of the most recent state survey results.	4 120	d. Medicare Services contact information 2.) The Social Services staff will interview residents and inform them of the locations of the above information. The locations will also be posted in the monthly newsletter. 3.) The contact information of the Ombudsman, the Dept. of Health/Medicaid Services and Medicare contact information will be discussed at every resident council meeting and minutes will be taken during the meeting. The Ombudsman will continue to visit the Resident Council Annually. The next visit will occur on December 7, 2018.The above information will be posted on each floor and will be included in the resident manual. 4.) The Social Services staff will conduct resident interviews quarterly to reinforce information to residents of the locations of the above information. Social Services will monitor monthly that posters are visible and at eye level for the residents.	

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	125013	A. BUILDING: _____ B. WING _____	09/27/2018

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

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4 120	Continued From page 4 An interview was conducted with the community life director on 09/26/18 at 10:45 AM who showed the surveyor the location of the most recent state survey results located on the desk in the third floor library. Reviewed the resident council meeting minutes dated 09/08/17 to 09/07/18. No documentation was found to indicate that the state survey results or where they can be found were discussed with the residents during the resident council meetings.	4 120		
4 152	11-94.1-39(e) Nursing services (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: (1) Written procedures for personnel to follow in an emergency including: (A) Care of the resident; (B) Notification of the attending physician and other persons responsible for the resident; and (C) Arrangements for transportation, hospitalization, or other appropriate services; (2) All treatment and care provided relative to the resident's needs and requirements for documentation; and	4 152		10/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125013	A. BUILDING: _____ B. WING _____	09/27/2018

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

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4 152	Continued From page 5 (3) Medication or drug administration procedures that clearly define drug administration process, documentation, and authorized This Statute is not met as evidenced by: Based on record review and interview with resident and staff members, the facility did not ensure R190 of 1 residents reviewed received treatment to manage pain. The facility did not ensure R190's pain regimen was administered in accordance with the facility's pain numeric scale. Also, the LN was not aware of the parameters of the pain numeric scale. Findings include: R190 was admitted to the facility on 08/28/18 following a hospitalization. The admission diagnoses include: gastrointestinal hemorrhage; melena; other abnormalities of gait and mobility; muscle weakness (generalized); acute post hemorrhagic anemia; hemarthrosis, right shoulder; lymphedema, not elsewhere specific; acquired absence of left breast and nipple; and Type 2 diabetes mellitus without complications. On 09/24/18 at 09:30 AM an interview was conducted with R190. R190 reported she has pain to her right arm and leg. R190 states she is provided with pain medication; however, at times the medication is ineffective. The R190 stated that she is given tylenol, then four hours later provided with another dosage of tylenol. R190 acknowledged running hot water on her arms helps to alleviate the pain; however, she will still request a pain killer. R190 reported sometimes the pain is excruciating. R190 also states the pain and swelling interferes with her ability to	4 152	1.) The licensed nurse was immediately reeducated regarding the pain management protocol and to follow the policy on pain management. 2.) A review of residents on pain management shall be assessed to determine that proper pain control is provided. If a resident chooses not to follow the numeric scale, the nurse will document in the progress notes the reason for deviating from the pain protocol/procedure. 3.) The nursing management will in-service all nursing staff on the pain policy and procedures. 4.) All residents on pain management will be monitored to ensure compliance and proper pain management for all residents. Random checks will be conducted by the ADON to ensure that the pain policy is being followed.	

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	125013	A. BUILDING: _____ B. WING _____	09/27/2018

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

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4 152	Continued From page 6 perform activities of daily living. On the morning of 09/27/18, R190 was observed during physical therapy. R190 was asked whether she received pain medication prior to therapy. R190 responded she did not receive pain medication and does not experience pain during therapy. R190 reported she thinks movement helps her with the pain and this is why she has pain while asleep (due to lack of movement). On 09/26/18 at 7:55 AM a record review found the physician order for the following: tylenol tablet 325 mg give 650 mg by mouth three times a day for pain for two weeks (09/13/18 to 09/27/18), not to exceed 4 gm in 24 hour period; tylenol tablet 650 mg every four hours as needed for mild pain or discomfort, not to exceed 4 gm a day; oxycodone HCl tablet 5 mg give 2.5 mg by mouth every 4 hours as needed for moderate pain; and oxycodone HCl tablet 5 mg by mouth every 4 hours as needed for severe pain. The physician did not document in the orders the parameters for mild, moderate and severe pain. The admission pain assessment dated 08/31/18 notes R190 has times when her pain is horrible or excruciating at least three times daily. R190's pain was noted to be to her right arm and leg which increases with movement. Subsequent pain assessment done on 09/11/18 notes R190 has occasional pain which does not affect her sleep and the pain intensity was three. A review of R190's care plan found the facility developed a care plan which focuses on pain to R190's right arm/leg due to history of right mastectomy with chronic lymphedema. The interventions include R190's current	4 152		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125013	A. BUILDING: _____ B. WING _____	09/27/2018

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

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4 152	Continued From page 7	4 152		

pharmacological pain regimen as ordered by the physician. Also included are the following interventions: use of the numeric pain scale to monitor pain daily; monitor pain level during care and as needed with report to Charge Nurse when complaint of pain or signs and symptoms of pain is noted; pain to right arm/leg comes and goes and is not associated with movement or any particular position; assist with repositioning as needed to maintain proper body alignment for comfort; and diversify attention to interest of activities as tolerated. The care plan did not define the parameters for administering prn medication for pain.

On 09/26/18 at 8:59 AM an interview was conducted with the DON and licensed nurse (LN) 1. The staff members were asked what are the numeric parameters for mild pain, LN1 responded 1 to 3, the DON clarified parameters for mild pain is 1 to 4; moderate pain is 5 to 7; and severe pain is greater than 7.

R190's Medication Administration Record (MAR) for September 2018 was provided by the facility on 09/26/18. A review of the MAR documents prn of tylenol is to be administered for mild pain. The record notes R190 was given prn of tylenol for pain level of 5 on the following dates: 09/12/18 at 0112; 09/15/18 at 0058; and 09/26/18 at 0130. R190 received tylenol on 09/19/18 at 0028 for pain level of 6. The administration of the tylenol given on 09/26/18 at 0130 for a pain level of 5 was noted to be ineffective. R190 was then provided with 2.5 mg of oxycodone at 0405. On 09/15/18 the efficacy of the tylenol was documented as "U", undetermined.

Further review found administration of 5 mg of oxycodone for severe pain with numeric rating of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125013	A. BUILDING: _____ B. WING _____	09/27/2018

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

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4 152	Continued From page 8 5 was administered on 09/24/18 at 0139. R190 was also provided 5 mg of oxycodone on 09/20/18 at 0844 and 09/23/18 at 0148 for numeric rating of 6. R190 was provided oxycodone for severe pain, numeric rating of 7 on the following dates: 09/05/18 at 0859; 09/14/18 at 0038; 09/22/18 at 0048; 09/25/18 at 2214. On 09/26/18 the policy for pain was provided by the facility. The policy documents tylenol is administered for mild pain with a numeric scale of 1 to 4; opiods, codeine and tramadol is administered for moderate pain with a numeric scale of 5 to 7; and opiods, hydromorphone, methadone, morphine oxycodone for severe pain with a numeric scale of 7+ (seven plus). On 09/27/18 at 9:30 AM an interview and review of R190's MAR was reviewed with the DON. The DON confirmed R190's pain medication was not administered in accordance with the facility numeric pain parameters for mild (rating of 1-4); moderate (rating of 5-7); and severe (rating of greater than 7).	4 152		
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;	4 153		10/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125013	A. BUILDING: _____ B. WING _____	09/27/2018

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

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4 153	Continued From page 9 (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 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 observation, interview and record review the facility failed to ensure that a nutritionally at risk resident, R192 maintained an acceptable parameter of nutritional status which resulted in a severe weight loss of eight pounds in two weeks. The deficient practice had the potential to place the resident at a high risk of developing a pressure injury. Cross reference to F803 menus and nutritional	4 153	1.) R192 was immediately added to the NAR/HAR list for immediate attention from the Interdisciplinary team. The staff reinterviewed the resident on his food preferences to ensure that they are being followed. The RD revisited resident's meal intake, weight, and hydration status. R192's weight is being taken every other day for monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125013	A. BUILDING: _____ B. WING _____	09/27/2018

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

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4 153	Continued From page 10 adequacy. Findings include: During observation on 09/25/18 at 11:50 AM Family Member (F)1 was assisting R192 to eat his pureed meal. Stating that he doesn't like the pureed food and has lost weight. The EMR revealed that R192 was admitted on 09/06/18 with a diagnosis of unspecified dementia, dysphagia and atherosclerotic heart disease. R192 was ordered a cardiac, low cholesterol/ low fat diet with pureed texture. Weight gain equal or more than five pounds (lbs.) in 1 week to be reported. Lasix (a diuretic) 40 milligrams (mg) tab give 1 tab every day for hypertension. On 09/10/18 the speech language pathologist (SLP) recommended little supervision due to prolonged liquid hold in mouth while eating. Weight records revealed the following: R192's admission weight on 09/06/18 was 160.4 lbs. On 09/20/18 R192's weight was 152 lb, an eight lb weight loss. The dietary assessment dated 09/19/18 was reviewed. The registered dietitian (RD) noted R192 was at risk for inadequate oral intake continue current dietary orders. Nursing notes dated 09/22/18 were reviewed, R192 with an eight lb. weight loss in two weeks since admission. Buttock/ anal excoriation noted. R192's diet changed to regular diet pureed texture, regular consistency. Resource 2.0 60 milliliters (ml) twice per day (BID) with medication pass. Magic cup as extra dessert with meals. Snack in between meals: pureed banana, 2000 kcal pudding. two soups and a side tofu with	4 153	2.)A list of residents weight summary was printed to identify residents who experience an unintended weight loss of 5% or more in 1 month, or 10% in 180 days. The NAR/HAR meeting will be held weekly. Nursing staff will notify RD and MD within 24 hours if significant weight loss is noted. All residents weight shall be monitored weekly by RD for significant weight loss. 3.) NAR and HAR focus meeting will be conducted weekly with the ID team members so that unintended weight loss can be addressed immediately. The following procedures will be put in place: a.) Whenever a resident eats 25% or less, the caregiver will notify the Unit Nurse. b.)If a resident eats 25% or less for 3 consecutive meals, nurse will notify Dietitian or Food Service Supervisor, physician, and family. c.)Nursing staff will encourage residents to drink 1200c-2000cc of liquids daily. (Unless contraindicated Physician) d.)Anytime there is a 5% difference between weighing, CNA's will recheck the weight each day for the next 3 consecutive days. e.)If a weight loss is confirmed, CNA will promptly notify unit nurse and ID team to determine root cause. 4.) Unintended weight loss will be addressed as a PIP for Quality Assurance. The staff will be retrained on how to watch for potential signs of malnutrition.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125013	A. BUILDING: _____ B. WING _____	09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAUNALANI NURSING AND REHABILITATION CENTE	5113 MAUNALANI CIRCLE 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
4 153	Continued From page 11 lunch & dinner. Physician's note dated 09/24/18 was reviewed, R192 has lost weight recently, ordered 240 ml water every day and evening shift due to not meeting daily fluid goal. Meal intake and hydration flow sheet's revealed from 0 9/06/18 to 09/27/18 R192 ate >75% of the meal 36% of the time and did not meet the fluid goal of 1700 ml. During an interview with LN1 on 09/26/18 at 1:51 PM who stated if there is a significant weight loss of five percent or greater the doctor and dietitian are notified by the nurse. During an interview with the community life director on 09/27/18 at 11:45 AM who stated R192 is not on the nutrition at risk (NAR). On 09/27/18 at 12:08 PM R192 was sitting at the table with the SLP who was conducting a trial to advance his diet with chopped and minced texture. R192 appeared to be sleeping and the SLP placed an ice cube on his lip to try to rouse him. The SLP was unable to complete the trial for R192 who was sleeping. During a telephone interview with the registered dietitian (RD) consultant on 09/27/18 at 01:10 PM who stated that he was notified via e-mail on 09/22/18 of R 192's eight lb. weight loss. R192 should be monitored for NAR and that he would also recommend to hold the Lasix to see if the weight loss is actual weight loss or fluid loss. R192 should be on the NAR.	4 153		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125013	A. BUILDING: _____ B. WING _____	09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAUNALANI NURSING AND REHABILITATION CENTE	5113 MAUNALANI CIRCLE 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
4 153	Continued From page 12	4 153		

Based on observations, record review, and staff interview, the facility failed to ensure correct portion sizes were served according to the menu for 83 of 90 facility residents (19 receiving a pureed diet, 55 receiving a chopped or regular diet, and 16 receiving a minced diet). This deficient practice had the potential to affect the provision of adequate meals to meet each residents' nutritional needs.

Findings include:

Observation of the lunch service in the main dining room on 09/26/18 from 11:33 AM to 12:00 PM, revealed the following:

1. Puree
Cook1 served the following portion sizes for a pureed diet:
Pureed chicken, #24 scoop (1.33 ounces (oz.))
Pureed rice, 2 oz. scoop
Pureed vegetables, 2 oz. scoop

Per the 09/26/18 tray card for a regular pureed diet, the required portion sizes were:
Pureed chicken, 3 oz.
Pureed rice, #10 scoop (3.2 oz.)
Pureed vegetables, 4 oz.

2. Regular/Chopped
Cook1 served the following portion sizes for a chopped and regular diet:
Regular chicken, 3 oz. scoop

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125013	A. BUILDING: _____ B. WING _____	09/27/2018

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4 153	Continued From page 13 Regular rice, #16 scoop (2 oz.) Regular vegetables, 3 oz. scoop Per the 09/26/18 tray cards for regular and chopped diets, the required portion sizes were: Chicken, 4 oz. Rice, 4 oz. Vegetables, 4 oz. 3. Minced Cook1 served the following portion sizes for a minced diet: Minced chicken, #24 scoop (1.33 oz.) Minced vegetables, 2 oz. scoop Rice, #16 scoop (2 oz.) Per the 09/26/18 tray card for a minced diet, the required portion sizes were: Ground chicken, 4 oz. Ground vegetables, 4 oz. Rice, 1/2 cup (4 oz.) On 09/26/18 at 11:33 AM, Cook1 stated the tray card for each resident documented the appropriate portion size for their prescribed diet. Cook1 stated he was unsure of the sizes of the scoops he was using to serve all the foods. On 09/26/18 at 3:23 PM, the registered dietitian (RD) stated the cook should have served the portion sizes documented on each tray card. He was unsure whether the scoop size correlated with the actual weight of the foods, and would have to look into the matter. He stated, "It could be because of different weights of different foods . . . A 2 oz. scoop of rice may be a different size than 2 oz. scoop of vegetables." He stated he was unsure whether the facility had menus that specified the scoop size to use when serving foods. The RD stated he visited the facility about	4 153		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125013	A. BUILDING: _____ B. WING _____	09/27/2018

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

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4 153	Continued From page 14 twice weekly, but did not evaluate the portion sizes and serving process during the meals. He stated he did not provide education to the dietary staff regarding portion sizes. On 09/26/18 at 4:20 PM, Cook2 stated the scoop size, in ounces, correlated with the portion sizes listed on the tray cards. For instance, for a 4 oz. portion of a food, the #8 scoop which has a 4 oz. capacity should be used. The facility's 09/23/18 policy addressing "Resident Meals and Portion Sizes" documented the purpose was, "To provide all residents with a nutritious, tasty meal with standardized portions." The procedure was to serve 3 oz. of meat, ½ cup of rice, and ½ cup of vegetables. The policy documented, "Monitoring: Will be done by Dietary Manager [and the] Lead Cook."	4 153		
4 154	11-94.1-40(b) Dietary services (b) All diets prepared for residents shall be: (1) Prescribed by the resident's physician, physician assistant, or APRN with a record of the diet as ordered kept on file; (2) Planned, prepared, and served by qualified personnel according to diet prescription. The current Hawaii Dietetic Association Manual or The Manual of Clinical Dietetics of the American Dietetic Association or both shall be readily available to all medical, nursing, and food service personnel; (3) All diets shall appropriately meet the nutrient, texture, and fluid needs of each resident; and	4 154		9/28/18

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	125013	A. BUILDING: _____ B. WING _____	09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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4 154	Continued From page 15 (4) Therapeutic or special diets shall be planned by a dietitian and served accordingly as prescribed by the resident's physician, physician assistant, or APRN. This Statute is not met as evidenced by: Based on observations, record review, and staff interview, the facility failed to ensure correct portion sizes were served according to the menu for 83 of 90 facility residents (19 receiving a pureed diet, 55 receiving a chopped or regular diet, and 16 receiving a minced diet). This deficient practice had the potential to affect the provision of adequate meals to meet each residents' nutritional needs. Findings include: Observation of the lunch service in the main dining room on 09/26/18 from 11:33 AM to 12:00 PM, revealed the following: 1. Puree Cook1 served the following portion sizes for a pureed diet: Pureed chicken, #24 scoop (1.33 ounces (oz.)) Pureed rice, 2 oz. scoop Pureed vegetables, 2 oz. scoop Per the 09/26/18 tray card for a regular pureed diet, the required portion sizes were: Pureed chicken, 3 oz. Pureed rice, #10 scoop (3.2 oz.) Pureed vegetables, 4 oz. 2. Regular/Chopped Cook1 served the following portion sizes for a	4 154	1.) Dietary staff was in-serviced on 9/28/18 regarding the correct serving utensils usage and portion sizes according to residents' nutrition status. 2.) The Cooks were retrained on using the appropriate serving utensils to coincide with residents care plan. All meal tickets were reviewed to ensure correct portion sizes 3.)The recommended portion sizes of food items on daily diet tickets was updated in Meal Suite (Dietary program) based on the dietary guidelines. Portion sizes policies and procedures were reviewed and updated by the RD. 4.) The daily tray line service will be monitored by the RD, Food Service Assistant, and/or Community Life Director to ensure that portion sizes are being followed.	

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4 154	Continued From page 16	4 154		

chopped and regular diet:
Regular chicken, 3 oz. scoop
Regular rice, #16 scoop (2 oz.)
Regular vegetables, 3 oz. scoop

Per the 09/26/18 tray cards for regular and chopped diets, the required portion sizes were:
Chicken, 4 oz.
Rice, 4 oz.
Vegetables, 4 oz.

3. Minced
Cook1 served the following portion sizes for a minced diet:
Minced chicken, #24 scoop (1.33 oz.)
Minced vegetables, 2 oz. scoop
Rice, #16 scoop (2 oz.)

Per the 09/26/18 tray card for a minced diet, the required portion sizes were:
Ground chicken, 4 oz.
Ground vegetables, 4 oz.
Rice, 1/2 cup (4 oz.)

On 09/26/18 at 11:33 AM, Cook1 stated the tray card for each resident documented the appropriate portion size for their prescribed diet. Cook1 stated he was unsure of the sizes of the scoops he was using to serve all the foods.

On 09/26/18 at 3:23 PM, the registered dietitian (RD) stated the cook should have served the portion sizes documented on each tray card. He was unsure whether the scoop size correlated with the actual weight of the foods, and would have to look into the matter. He stated, "It could be because of different weights of different foods . . . A 2 oz. scoop of rice may be a different size than 2 oz. scoop of vegetables." He stated he was unsure whether the facility had menus that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125013	A. BUILDING: _____ B. WING _____	09/27/2018

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

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4 154	Continued From page 17 specified the scoop size to use when serving foods. The RD stated he visited the facility about twice weekly, but did not evaluate the portion sizes and serving process during the meals. He stated he did not provide education to the dietary staff regarding portion sizes. On 09/26/18 at 4:20 PM, Cook2 stated the scoop size, in ounces, correlated with the portion sizes listed on the tray cards. For instance, for a 4 oz. portion of a food, the #8 scoop which has a 4 oz. capacity should be used. The facility's 09/23/18 policy addressing "Resident Meals and Portion Sizes" documented the purpose was, "To provide all residents with a nutritious, tasty meal with standardized portions." The procedure was to serve 3 oz. of meat, ½ cup of rice, and ½ cup of vegetables. The policy documented, "Monitoring: Will be done by Dietary Manager [and the] Lead Cook."	4 154		
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (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 (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. This Statute is not met as evidenced by:	4 159		10/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAUNALANI NURSING AND REHABILITATION CENTE	5113 MAUNALANI CIRCLE HONOLULU, HI 96816

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4 159	Continued From page 18 Based on observations, record review, and staff interviews, the facility failed to ensure foods were stored, distributed, and/or served at appropriate food holding temperatures and in a sanitary manner. This deficient practice had the potential to propagate an outbreak of foodborne illness. Findings include: 1) Observation of the lunch service in the main dining room on 09/26/18 from 11:33 AM to 12:00 PM revealed the following: Chicken salad sandwiches were stacked three to four sandwiches high in a pan sitting over ice behind the steam table. Cook1 monitored the temperature of the sandwiches at 49 degrees Fahrenheit (F). He stated it was monitored at 42 degrees F when brought out from the kitchen. The cook stated he expected cold foods to be below 45 degrees F. The cook began to serve the chicken salad sandwiches at 11:46 AM without cooling them to the appropriate temperature first. Cook1 served approximately nine sandwiches during the meal. Review of the 09/26/18 food temperature log revealed the chicken salad sandwiches were monitored at 42 degrees F. On 09/26/18 at 3:23 PM, the registered dietician (RD) stated he visited the facility two times a week, where he conducted kitchen inspections and spent time in the dining room in addition to completing resident assessments. The RD stated he did not look at food temperatures as part of his inspections. The RD stated Cook1 should have disposed of the sandwiches that were above the appropriate holding temperature and should not have served them to residents. He stated cold	4 159	1.) The dietary staff was in-serviced on 9/28/18 regarding appropriate temperatures and proper holding temperature. 2.) Refrigerator temperature logs were completed by designated dietary staff daily. The Kitchen Supervisor or designee will sign off on temperature logs and the dietary staff will inform on-duty kitchen supervisor of any out-of-range temperatures. 3.) Dietary staff will consistently monitor the refrigerator or freezer temperatures and maintain a written log of all temperatures. In addition to the already serv-safe trained cooks, all other dietary staff will also become serv-safe trained. 4.)Temperature logs completed by the cook(s) will be monitored/verified daily by the RD, The Kitchen Supervisor, or the Community Life Director. 1.)Non staff retrieving trays from the dietary carts was stopped immediately. Family members were educated regarding the policy of the facility on distributing food, and that only staff shall remove food/beverages from med carts/refrigerators 2.)Maunalani Management team will monitor all dining areas to observe the deficient practice does not reoccur. A memo will be posted to remind family/ friends to refrain from removing any food/beverages and to ask staff for assistance.	

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	125013	A. BUILDING: _____ B. WING _____	09/27/2018

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4 159	Continued From page 19 foods should be 41 degrees F or below. The facility's 09/21/18 policy addressing "Food Temperatures" documented, "Cold Food Serving Temperatures shall be 41 (degrees F) or below according to the Department of Health guidelines." 2) On 09/24/18 at 11:25 AM During dining observation on second floor outside Orchid dining room door, observed female family member of R16 pouring juice from juice cart. Same family member then opened metal food tray cart with other residents' lunch trays inside and subsequently took out one tray and left. A few minutes later, observed another female family member coming from room 218 to the metal food tray cart and proceeded to take two lunch trays out and headed back to room 218. This family member also poured juice from the juice cart. On 09/24/18 at 04:35 PM Interview with DON and Assistant Director of Nursing (ADON) who confirmed that residents' family members should not be taking food trays out from the food tray cart by themselves. No one but staff should be distributing out food trays.	4 159	3.) Staff will be inserviced on meal distribution service. Maunalani staff will enforce distribution procedures by retrieving all meal trays for residents. The monthly newsletter will also remind families to ask for assistance with retrieving meal trays. 4.) Maunalani management team will monitor each meal service to make certain that family members are being assisted and not removing trays by themselves.	
4 182	11-94.1-45(a) Dental services (a) Emergency and restorative dental services shall be available to each resident. This Statute is not met as evidenced by: Based on resident observation, resident interview,	4 182	1.) Nursing immediately followed-up with	10/31/18

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	125013	A. BUILDING: _____ B. WING _____	09/27/2018

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4 182	Continued From page 20 record review, and staff interview, the facility failed to refer one resident (R31) of 36 sampled residents for dental services for denture replacement in a timely manner. This deficient practice had the potential to affect R31's access to needed dental services. Findings include: Per the EMR "Profile," the facility admitted R31 on 07/25/18. R31's 07/14/18 quarterly "Minimum Data Set (MDS)," a comprehensive assessment completed by facility staff that drives the care planning process, indicated R31 did not have broken teeth or loose-fitting dentures (Section L: Oral/Dental Status). A "Care Plan" addressing performance of activities of daily living, revised on 07/11/18, documented the interventions, "I go to VA [Veteran's Administration] dentist as needed. Call my wife for scheduling as I need someone to go with me" and "I can brush my teeth after set-up. I use an electric tooth brush." On 09/24/18 at 1:23 PM, R31 was observed with no upper teeth and several missing teeth on the bottom. He stated he used to have dentures, but no longer had them; he was unsure what had happened to them. He stated he was interested in getting new dentures and would like to see the dentist. A 04/18/18 "Dental Progress Note" documented, "Pt (patient) has no pain. Pt has no teeth on the uppers and pt lost his FUD (full upper denture) been missing 5 months. Pt wants a new upper denture. Pt needs a good cleaning - black	4 182	R31 and spouse regarding dental services. R31 confirmed no interest in dentures but spouse was going to set up dental visit with the VA dentist. 2.) Nursing staff reviewed the dental consultant notes to see if there are items to follow-up. No current pending items at this time. 3.) The Health Information department will deliver the hard copy documentation to the DON and Charge Nurse. The Nurse will sign off that she has read the dental consultant report and will make arrangements to follow-up. The Health Information will then scan the document to the software system. 4.) The HI Manager will submit a report at the monthly PIP meetings to ensure that the residents are receiving dental consultations/services and necessary follow-ups have been completed.	

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	125013	A. BUILDING: _____ B. WING _____	09/27/2018

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4 182	Continued From page 21	4 182		

calculus supragingival. Pt interested FUD and a PLD (partial lower denture) metal. Pt states never fit well. Pt states he has dental (insurance), and wants a FUD."

On 09/26/18 at 1:38 PM, the admissions manager (ADM) was asked to provide any follow up done to the resident's request for dentures on 04/18/18.

A 09/26/18 "Nursing Note," written at 2:19 PM, documented, "Resident was interviewed today (to determine) if he has any pain when eating, said 'no.' Observed still with natural teeth, multiple missing teeth upper and lower. Asked if he wants dentist to make dentures for him, said 'no, I used to have partial dentures maybe 2-3 years ago, I don't need it. I usually see my VA dentist.' Agreeable to have wife schedule him for dental cleaning with VA. Action: Called his wife, said that she will arrange for VA dental cleaning. Per wife, last time done was December. Response: Wife was appreciative of call."

On 09/26/18 at 3:53 PM, the ADM stated she spoke to the nurse, who wrote a note today about the resident's dental needs. She stated she would have expected the nursing staff to follow up on the dentist's note from 04/18/18 at the time, and the resident's request for dentures should have been addressed sooner.

On 09/27/18 at 8:24 AM, the second-floor unit manager (UM2) stated R31 reported to her he had dentures 'maybe two or three years ago', but she had never seen him with them. UM2 called R31's wife who reported he did used to have dentures, but she was unsure where they were currently. UM2 reported R31 stated he was not interested in dentures anymore and stated, "we

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4 182	Continued From page 22 agreed to a cleaning with the VA." UM2 stated, "I did not know anything about the dental consult on 04/18/18; this is the first time I've heard of it. Medical Records receives the consults and puts them in the chart . . . the dentist used to tell us if there were any concerns . . . but now we may have to revisit our process." UM2 stated R31 was "someone who changes his mind a lot. Typical of his personality . . . Could be attention-seeking behaviors."	4 182		