STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125057	A. BUILDING: _____ B. WING _____	12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULANA MALAMA	91-1360 KARAYAN STREET EWA BEACH, HI 96706

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4 000	Initial Comments A state re-licensure survey was conducted by the Office of Health Care Assurance (OHCA) on 11/28/18 - 12/3/18.	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: The right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive; Based on interview and record review, the facility failed to obtain documentation that a resident or a resident's representative was given an opportunity to formulate advanced directives or had a valid advanced directive for five of 12 residents (Resident (R) 11, 12, 20, 25 and 14) selected for review. This deficient practice had the potential to affect residents admitted to the facility. Findings Include: 1) On 11/28/18 11:44 AM, review of R11, R12,	4 118	Parents of the affected residents (R11, 12, 20, 25 and 14)were contacted via phone and certified mail concerning Advance Directives, giving them the opportunity to discuss the matter or work with the Social Worker on formulating an Advance Directive. If they declined, it was documented in the resident's chart that the opportunity was presented and they were not interested at this time. Social Worker will review all charts to determine if any lack either an Advance Directive or documentation that the opportunity to formulate one was given. If there is no documentation that the	1/16/19

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4 118	Continued From page 1 R20, and R25's records did not reflect documentation that the resident or resident's representative was given an opportunity to formulate advanced directives or had an advanced directive. On 11/30/18 09:18 AM Social Worker 1 (SW1) was interviewed and asked if she had advanced directive documentation for R11, R12, R20, and R25. SW1 responded those residents had POLST documentation. SW1 was informed that the POLST is not an advanced directive. SW1 validated that if the POLST is not an advanced directive, then R11, R12, R20, and R25 do not have advanced directives. 2) On 11/30/18 at 10:20 AM, during an interview with SW1, she confirmed for R14, per the court order in the clinical record, R14's legal guardians are allowed to formulate an advance directive. SW1 acknowledged that although an advance directive for R14 was talked about during their annual review of the resident's code status, SW1 verified "it was only discussed" and was not documented. SW1 stated going forward, the information about and a formulation of an advance directive will be reviewed with R14's guardians.	4 118	opportunity was presented, the Social Worker will follow up with the family to determine possible outcomes of that decision and document once a decision has been made. Admissions forms were changed to reflect documentation that Advance Directives were covered and the opportunity to formulate one was presented. At admissions and annual Care Conferences, the chart will be reviewed to determine if the family would like to consider an Advance Directive at that time, if they have not already formulated one.	
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:	4 152		1/16/19

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4 152	Continued From page 2 (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 (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 interview and record review, the facility failed to notify the physician immediately of one of 12 residents (Resident (R) 25) who experienced weight loss in a month and was selected for review. This deficient practice had the potential to affect all 17 residents in the survey sample. Findings Include: On 11/28/18, R25's record was reviewed, and it reflected R25's weight loss on 11/01/18. The facility's "Daily Skilled Nurse's Note," dated 11/01/18 did not reflect that the physician was immediately informed of R25's weight loss. R25's care plan was reviewed and it also did not reflect the weight loss recorded on 11/01/2018 nor that it was reported to her physician. Communication	4 152	Although the Physician was not immediately notified for resident's (R25) weight loss, the Physician was monitoring the resident's weight due to other complications the resident was experiencing from the prior month. Because Kulana Malama employs a full-time Physician, he was aware of the weight loss the next time he came in to the facility. All residents' charts were checked for significant weight loss once the matter was brought to our attention. No other residents were found to be affected. The Resident Weight Change Record was	

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4 152	Continued From page 3 logs to the physician were reviewed and they also did not reflect the weight loss was reported to physician on 11/01/2018, or thereafter. On 11/30/18 at 09:27 AM, the Director of Nursing (DON) was interviewed. He was asked if R25's weight loss was reported to the physician. The DON replied that he didn't know and would have to check documentation. DON was given the opportunity to review R25's documentation. DON validated the physician was not informed immediately of R25's weight loss.	4 152	modified to include easier calculations of weight change. Staff were in-serviced on the new form, how to complete it, and the proper way to calculate percentage (%) weight loss or gain. The Director of Nursing or designee will audit the Resident Weight Change Record monthly x 3 months, then quarterly x 1 year. Any areas for concern will be reported to the Quality Assurance Committee.	
4 174	11-94.1-43(b) Interdisciplinary care process (b) An individualized, interdisciplinary overall plan of care shall be developed to address prioritized resident needs including nursing care, social work services, medical services, rehabilitative services, restorative care, preventative care, dietary or nutritional requirements, and resident/family education. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement an individualized, interdisciplinary overall plan of care to address resident needs, including routine dental care for one of 12 residents (Resident (R) 14) and insulin use for another resident (R22), selected for review. This deficient practice had the potential to affect all 17 residents for which a care plan may need to be developed. Findings Include: 1) On 11/29/18 at 08:24 AM, during a family interview conducted for R14, the family member	4 174	1) An oral/dental care plan was developed and implemented for resident (R14) affected. The dentist was contacted and came in to assess the resident's needs and to give an in-service to staff on dental care. 1) All charts were audited and found that many charts were lacking oral/dental care plans. Any charts missing an oral/dental care plan were addressed. 1) All future admissions will have an oral/dental care plan created upon	1/11/19

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4 174	Continued From page 4 stated the bottom part of R14's teeth had a lot of plaque build-up. The family member was not sure when the facility's dental consultant last saw her. Record review revealed a dental consultant's (licensed dentist) note, which stated R14's last dental screening was done on 2/20/17. The dental consultant's comments were: "Improve oral hygiene - recommend prophy." On 11/30/18 at 10:13 AM, during an interview with registered nurse (RN) 1, she confirmed the resident's dental prophylaxis (cleaning) had not been scheduled since the 2/20/17 recommendation by the dental consultant. RN1 said their dental consultant (a licensed dentist), was scheduled to come and see her in October 2018, "but he didn't come in and we haven't heard from him since." Further review found R14 did not have a comprehensive care plan developed for her dental/oral hygiene status. On 12/03/18 at 08:48 AM, a telephone interview with the facility's consultant MDS (Minimum Data Set) coordinator (MDS-C) was done. He acknowledged completing R14's annual MDS dated 08/22/18, and the 11/9/18 quarterly assessment. Both areas for Section L, oral/dental, showed that nothing had been marked. He was not aware that the last time R14 was examined by the dental consultant was in February of 2017 with a recommendation for dental cleaning. The MDS-C said he should have reviewed this, but confirmed he failed to do so. Thus, there was no oral/dental assessment completed and no oral/dental comprehensive care plan developed. 2) For R22, a review for unnecessary medication	4 174	admission if necessary. 1) At admission and quarterly care conferences, care plans will be reviewed to ensure we are following the care plans and addressing the needs of the resident. 2) A care plan was created for affected resident's (R22) insulin use. 2) All charts were audited to ensure that residents with a diagnosis of diabetes had a comprehensive care plan to address their insulin usage if applicable. No other residents were found to be affected. 2) All future residents with a diabetes diagnosis and insulin usage will have an insulin care plan implemented if applicable. 2) At admissions and quarterly care conferences, care plans will be reviewed to ensure we are following care plans and addressing the needs of the resident.	

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4 174	Continued From page 5 use for insulin was done. R22 has a diagnosis of diabetes mellitus and receives Lantus insulin 40 units by subcutaneous (SQ) injections twice daily. R22 also receives Humulin R (regular) insulin 5 units by SQ injections if his blood sugar goes above 200 mg/dl (milligrams per deciliter). Record review however, found there was no comprehensive care plan developed for R22's insulin use. On 11/30/18 at 09:46 AM, both the Director of Nursing (DON) and the Staff Development Coordinator (SDC) confirmed there was no comprehensive care plan for the resident's insulin use and RN1 was developing one.	4 174		
4 183	11-94.1-45(b) Dental services (b) Each resident or resident's legal guardian, or surrogate shall select the dentist of his or her choice, and the facility shall assist each resident to obtain necessary dental care by making arrangements for appointments and transportation, as requested. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to promptly assist and/or provide each resident necessary dental care by making arrangements for appointments for routine dental services to meet the resident's needs for one of 17 residents (Resident (R) 14) selected for review. This deficient practice had the potential to affect all residents currently residing in the facility. Findings Include: On 11/29/18 at 08:24 AM, during a family	4 183	Kulana Malama's consultant Dentist was contacted and came in to address the needs of the affected resident (R14). Other residents were checked by the Dentist to ensure their needs were addressed and proper oral care was present. The Dentist also in-serviced staff on dental care. Dentist has agreed to routinely visit the residents more frequently to ensure their oral/dental needs are being addressed.	1/15/19

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4 183	Continued From page 6 interview conducted for R14, the family member stated the bottom part of R14's teeth had a lot of plaque build-up. The family member was not sure when the facility's dental consultant last saw her. Record review revealed a dental consultant's (licensed dentist) note, which stated R14's last dental screening was done on 2/20/17. The dental consultant's comments were: "Improve oral hygiene - recommend prophy." On 11/30/18 at 10:13 AM, during an interview with registered nurse (RN) 1, she confirmed the resident's dental prophylaxis (cleaning) had not been scheduled since the 2/20/17 recommendation by the dental consultant. RN1 said their dental consultant (a licensed dentist), was scheduled to come and see her in October 2018, "but he didn't come in and we haven't heard from him since." RN1 acknowledged there was no follow-up by the facility since.	4 183	Visits will happen monthly to initially complete all residents' examinations, then on a scheduled basis for maintenance of their oral care. The Director of Nursing or designee will track the visits of the consultant Dentist. If visits do not occur as agreed upon, the facility Administrator will contact the consultant Dentist to discuss the matter. An additional Dentist was contacted and will be met with to serve as a backup in the event the primary consultant Dentist cannot make it to the facility timely.	
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 and interview, the facility failed to maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases and	4 203	Nursing management was able to determine who RN(2) was and immediately proceeded to re-educate the nurse on proper use of gloves and	1/11/19

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4 203	Continued From page 7 infections. Findings Include: Observation of medication administration on 11/30/18 at 09:40 AM for resident (R) 6 with Registered Nurse (RN)2 demonstrated a compromise in infection control. During the passing of the medications for R6, the RN2 put one set of gloves on and then touched the feeding tube, drew the curtains closed, touched the foot board of the bed and attempted to open a drawer. RN2 did not change gloves and started passing meds via tube feeding. During an interview with RN2 after the medication pass, she stated, "I forgot to change gloves."	4 203	infection control practices. All staff were in-serviced on proper glove usage and infection control techniques. Monitoring sheets were created for audits to be performed by various administration team members. Areas of focus are hand hygiene and proper infection control practices. Any infractions will require re-education at the time it is observed. Audits will be turned in to the Director of Nursing for further follow-up if needed. Audits will occur every week x 4 week, then if determined appropriate, every two weeks x 2 months, then quarterly x 1 year.	