STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125047	A. BUILDING: _____ B. WING _____	04/12/2019

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HALE OLA KINO	1314 KALAKAUA AVENUE, 2ND FLOOR HONOLULU, HI 96826

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4 000	Initial Comments A re-licensure survey was conducted between April 8, 2019 to April 12, 2019. The facility reported census was 30 residents at time of entrance.	4 000		
4 102	11-94.1-22(d) Medical record system (d) Records to be maintained and updated, as necessary, for the duration of each resident's stay shall also include: (1) Appropriate authorizations and consents for medical procedures; (2) Records of all periods, with physician orders, of use of physical or chemical restraints with justification and authorization for each and documentation of ongoing assessment of resident during use of restraints; (3) Copies of initial and periodic examinations and evaluations, as well as progress notes at appropriate intervals; (4) Regular review of an overall plan of care setting forth goals to be accomplished through individually designed activities, therapies, and treatments, and indicating which professional services or individual is responsible for providing the care or service; (5) Entries describing all care, treatments, medications, tests, immunizations, and all ancillary services provided; and (6) All physician's, physician assistant's, or APRN's orders completed with appropriate documentation (signature, title, and date).	4 102		5/8/19

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4 102	Continued From page 1 This Statute is not met as evidenced by: Based on interviews and record reviews (RR) the facility failed to maintain medical records in accordance with accepted professional standards and practices for two of 23 residents (R15 & R8) sampled for survey. Findings Include: 1) On 04/08/19 at 10:22 AM, interviewed R15 who reported that a male residents wanders into her room and has occurred four to five times now. The R15 stated that the facility now uses a red tape across her doorway with "Stop Do Not Enter" signage printed on it. On 04/11/19 at 08:00 AM, RR on R15 did not find any documentation in nursing notes and/or care plan of the incident investigated and resolved. Interviewed the director of nursing (DON) and she couldn't provide any documentation but could verbalize about the incident and how it was resolved. The DON showed the red doorway tape "Stop DO NOT ENTER" signage that was ordered, and stated that R15 aware that it is near her doorway when needed. The staff are aware of this wandering resident and monitors his whereabouts when he is out and about in the hallways. 04/11/19 10:05 AM interviewed social services coordinator, and he had a grievance binder with R15's grievance regarding male resident entering her room; provided. According to the SSC grievances that are handled within 24 hrs are not documented in resident's medical records. The R15's care plan (CP) dated "03/23/18 to promote highest level of well-being; safety;	4 102	4102 - 11-94.1-22(d) - Medical Record System REGARDING RESIDENT #15: (IDR) 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; - The Interdisciplinary Team (IDT) continues to monitor Resident #15 to ensure that other residents do not enter the room uninvited. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; - Residents who express grievances have the potential to be affected. Upon review of the grievance log for last 2 months, there are no other residents having been affected by wandering residents entering their room uninvited. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; - The social worker has been re-educated regarding the documentation requirements related to resident grievances. When a resident expresses a grievance, Social Services will a enter note in the resident□s record documenting the nature of the grievance and outlining the steps taken to resolve the issue. Should a grievance require ongoing monitoring of a concern, the resident□s care plan will revised/updated as appropriate to reflect	

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4 102	Continued From page 2 independence; honor preference; resident centered care; with by date 6/19; . . . 10. Care related special instructions: -a resident who wheels self on hallway gets near residents door-resident is bothered with this resident's presence even near the door only - requested something to deter this resident to ensure this person does not enter residents room Resident (251) agreed to use a "do not enter sign" placed on her door (251) - will monitor effectiveness - will change CP as necessary. - sometimes resident also requests door to be completely closed - if it happens - staff regularly rounds resident for safety. " This CP was the only documentation of R15's reported incident of a male resident wandering into her room. 2) On 04/10/19 at 02:19 PM, interviewed the staff development manager (SDM) and requested R8's MRR sheets for the past six months. The SDM provided MRR's dated 10/18; 11/18; 12/18; and 01/19. The SDM had to check with the director of nursing (DON) for the 02/19 and 03/19 MRRs . On 04/11/19 the SDM provided R8's pharmacist MRR done on 02/26/2019 and 03/19/19. On the 02/26/19 MRR, the pharmacist noted that R8 was receiving the combined use of more than one antidepressant and the physician should consider treating R8's depression with a single antidepressant. The MRR did not document the medical doctors (MD) response or a signature. The 03/19/2019 MRR noted that R8 was on an antidepressant whose dose should be evaluated and considered for gradual dose taper, and the form was not acknowledged nor signed by the MD. Interviewed the DON and she provided	4 102	current IDT measures to resolve and monitor the situation. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. - All grievances are reviewed during daily team meetings to ensure that resident concerns and/or complaints are handled promptly. The Administrator ensures that all complaints are forwarded to the appropriate department for review and resolution within 3 business days. The administrator/designee will audit social service documentation monthly for three months to ensure that the resident□s records contains all pertinent information related to a grievance. The Social Worker reviews the Grievance Log and submits reports to the QAA Committee for review and further recommendations. Regarding Resident #8 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Upon learning of the deficient practice, Medical Records contacted the attending physician to properly sign and date the MRR. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. An audit was conducted by the medical	

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4 102	Continued From page 3 documentation that the MD was notified via phone of pharmacy recommendations on 03/19/19. The physician wanted it placed in his communication binder at the facility and there were no new orders on that date. On 04/12/19 the DON provided the MD's acknowledgement on the 02/26/19 MRR, "Pt stable on current psych meds . . ." and on the 03/19/2019 MRR, "Keep same RX," with MD initials. The MD was in the facility, and the DON requested that he acknowledge both MRRs. The MD did not sign or date the MRRs acknowledgements. The facility failed to ensure that the medical records for R15 and R8 were completed and provided sufficient information for staff to respond to the changing status and needs of the residents; accurately documented with dates and times; and, systematically organized.	4 102	records on 5/3/19 and determined no other residents are affected with the same deficient practice. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. The Physicians will be apprised to document their full signature and date when reviewing pharmacist recommendations documented in an MRR. The Medical Records Coordinator will audit pharmacist reports (MRR) to validate that physicians have included a full signature and a date when completing their review of the pharmacist□'s recommendations. Medical Director will address all non-compliant MMR. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. The Medical Records Coordinator will submit reports related to completion of physician reviews of MRRs to the QAA Committee for further review and recommendations.	
4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not	4 149		5/8/19

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4 149	Continued From page 4 limited to the following: (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; (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 (3) Ongoing evaluation and monitoring of direct care staff to ensure quality resident care is provided. This Statute is not met as evidenced by: Based on interviews, observations, record, and policy reviews, the facility failed to evaluate and revise the care plan for one of 23 sampled residents (R) 15, to prevent resident to resident altercations. Findings Include: On 04/08/19 at 10:22 AM, interviewed R15 and the resident revealed that another resident (male) wonders into her room. According to R15, this male resident had wondered into her room four to five times, self propelling his wheelchair. R15 stated that she would yell at this male resident to	4 149	4149 - 11-94.1-39(b) Nursing Services - IDR 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; - The Social worker met with resident #15 who is aware of the plan of care and in agreement with interventions in place. The resident states that she feels safe in the facility. The care plan has been updated to interventions related to resident to resident altercations.	

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4 149	Continued From page 5 get out of her room, because she is bedridden due to a broken right knee and left ankle. The R15 further stated that the incidents were reported to the administrator and the male resident is being monitored, and a red stop tape is placed across her doorway. Also, with renovations that were being done in the hallways, the male resident is unable to self-propel around the facility. Due to renovations taking place there was no red stop tape across R15's doorway on this date. 04/11/19 09:00 AM record review (RR) on R15 found that there was no documentation regarding the resident's report of a male resident entering her room and how the facility addressed the situation. Interviewed the DON and she stated that the situation was resolved, and purchased several red doorway tape with printed "Stop DO NOT ENTER" signage. Queried the DON on documentation for assessment done on R15, and whether she feels safe in facility. The DON could not find documentation in R15's records and stated that the social services coordinator (SSC) may have documentation in his binder. Queried whether staff are aware of this wandering male resident and knows to monitor his whereabouts when he is out and about in the hallways, and the DON stated that staff are aware and in the male resident's care plan. On 04/11/19 at 10:05 AM, interviewed the SSC and he provided R15's grievance regarding male resident entering her room that was kept in the SSC grievance binder. Queried SSC whether a care plan (CP) was formulated to protect R15 from the male resident. The SSC stated that they made a CP for the other resident instead.	4 149	2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; - The Social worker has conducted interviews with all current residents and found no other resident with concerns regarding resident to resident altercations. No other residents verbalized □feeling unsafe in the facility□. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; - All Grievances are reviewed during daily team meetings to ensure that appropriate persons/departments are assigned to resolve the resident□s concerns. The social worker reviews/updates the resident□s care plan to ensure that appropriate interventions are documented if ongoing management is required. The assigned person/department reports back to the team within 5 business days regarding the resolution of the grievance/concern. The Administrator and or designee will follow up 1 week after with the concerned resident if the resolution in place is effective. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. - The social worker maintains the Grievance Log to ensure that all resident concerns/grievances are resolved promptly to the resident□s satisfaction and submits monthly reports to the QAA committee for review and	

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4 149	Continued From page 6 The SSC also stated, that grievances that are handled within 24 hours are not documented in resident's medical records. Further RR on R15 found a CP dated 03/23/18 to "promote highest level of well-being; safety; independence; honor preference; resident centered care with goal, "by date 6/19 . . . 10. Care related special instructions: a resident who wheels self on hallway gets near residents door; resident is bothered with this resident's presence even near the door only; requested something to deter this resident to ensure this person does not enter residents room; R15 agreed to use a "do not enter sign" placed on her door (rm 251); will monitor effectiveness; will change CP as necessary; sometimes resident also requests door to be completely closed; if it happens - staff regularly rounds resident for safety. "	4 149	recommendations.	
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: Based on observation and interview, the facility failed to label pies and other food items in the	4 159	4159 11-94.1-41(a) Storage and Handling of Food - IDR	5/8/19

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4 159	Continued From page 7 freezer. This deficient practice had the potential to put residents at risk for serious complication from foodborne illness as a result of their compromised health status. Findings Include: On 04/08/19 at 08:06 AM the initial kitchen tour in the facility found several food items that were past the expiration date. In the cook prep refrigerator an opened bag of defrosted chicken thighs had a "discard date of 4/7," and in the freezer section there was an opened bag of chicken patties with no expiration and/or open date, and other bags of frozen items with no expiration dates. In the walk-in produce refrig there was a tray of yogurt containers with expiration dates of 4/05 and a tray of stir fry vegetables with expiration date of 4/3. The reach-in freezer contained 12 sugar free pies with no use by and/or expiration dates. On 04/11/19 at 09:09 AM interviewed the Sous Chef and Food & Beverage Manager, and they provided the facility policy for food & beverage services to ensure that kitchen staff will label and discard food items appropriately. The "Labeling and Discarding Food Items; Standard Operating Procedure - 19; Policy: Food and Beverage services will label and discard food items appropriately."	4 159	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; - Any undated food was removed based on the observations of the surveyor. No residents were identified as having been affected by the observed practice 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; - All residents have the potential to be affected. The Food & Beverage Manager inspected all food storage to ensure that there were no additional food items that exceeded expiration dates. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; - Food & Beverage staff have been reeducated regarding food labeling and rotation according to facility procedural guidelines. All stored food items will be labeled appropriately and discarded according to expiration dates as directed by the facility procedural guidelines. - The Food & Beverage Manager/designee inspects food storage daily to ensure that no food items have exceeded the expiration. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. - The Food and Beverage Manager submits reports regarding food storage	

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4 159	Continued From page 8	4 159	compliance to the Administrator for review by the QAA committee.	
4 166	11-94.1-42(d) Physician services (d) Physicians, physician assistants, or APRNs shall visit the facility as necessary to assure that adequate medical care is being provided, review plan of care, make pertinent recommendations, and determine appropriate level of care of resident. This Statute is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure that the pharmacist's medication regimen review (MRR) was acted upon by the medical doctor (MD) for one of five residents (R8) sampled for unnecessary medications. Findings Include: On 04/10/19 at 02:19 PM, interviewed the staff development manager (SDM) and requested R8's MRR sheets for the past six months. The SDM provided MRR's dated 10/18; 11/18; 12/18; and 01/19. The SDM needed to check with the director of nursing (DON) for the 02/19 and 03/19 MRRs . On 04/11/19 the SDM provided R8's pharmacist MRR done on 02/26/19 and 03/19/19 and both MRRs had pharmacist recommendations that were not acknowledged by R8's MD. On the 02/26/19 MRR, the pharmacist noted that R8 was receiving the combined use of more than	4 166	4166 - 11-94.1-42(d) Physician Services - IDR 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; - Resident #8 was evaluated by the physician on 4/10/19. The pharmacy MRRs dated 2/26/19 and 3/19/19 have been acknowledged by the medical doctor including the physician□s signature and date. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; - All recommendations generated from the MRRs conducted by the licensed pharmacist on 4/22/19 and 4/24/19 have been acknowledged by MD. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;	5/8/19

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4 166	Continued From page 9 one antidepressant and the physician should consider treating R8's depression with a single antidepressant. The MRR did not document a physician response or a signature. The 03/19/19 MRR noted that R8 was on an antidepressant whose dose should be evaluated and considered for gradual dose taper, and the form was not acknowledged by the MD nor signed by him. Interviewed the DON and she provided documentation that the MD was notified via phone of pharmacy recommendations on 03/19/19. The MD wanted the MRR placed in his communication binder at the facility and there were no new orders on that date. On 04/12/2019 the DON provided the MD's acknowledgement on the 02/26/19 MRR, "Pt stable on current psych meds . . ." and on the 03/19/19 MRR, "Keep same RX," with MD initials. The MD was in the facility and the DON requested that he acknowledge both MRRs on this date. The facility failed to ensure that R8's MD documented in the resident's medical record that the MRR was reviewed for any identified irregularities, and rationale if there is no change in the medication(s).	4 166	- The licensed nurse notifies the attending physician of pharmacy recommendations. Verbal acknowledgement including new orders are documented in the resident□s medical record. The Medical Director will be consulted after 72 hours for all pharmacy recommendations not acknowledged by the resident□s attending physician. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. - The pharmacist provides the DON a summary report of MRR recommendations upon completion of the monthly consultative visit. The DON /designee reviews the individual resident reports to ensure that there is documentation of physician review and acknowledgement of the consultant pharmacist□s recommendations. The DON/designee submits monthly reports related to compliance with physician acknowledgement of MRR recommendations to the QAA committee for review and recommendations.	