Hawaii Dept. of Health, Office of Health Care Assuranc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HI02LTC056H	A. BUILDING: _____ B. WING _____	04/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE HO ALOHA	2670 PACIFIC HEIGHTS ROAD HONOLULU, HI 96813

(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 focused relicensing survey was conducted by the Office of Health Care Assurance (OHCA) on 04/30/2020. Due to the COVID-19 pandemic, the relicensure survey focused on selected sections of the regulatory requirements of the Hawaii Administrative Rule, Title 11, Chapter 94.1, Nursing Facilities. The sections included: Infection Control; Resident Abuse, Neglect, and Misappropriation of Resident Property; Admission, Transfer and Discharge; Nursing Services; and Emergency Preparedness. The facility was found not to be in compliance with the regulatory requirement at 11-94.1-29 (Resident Abuse, Neglect, and Misappropriation of Resident Property). The census was 55 residents. There were no residents in the facility that were positive for COVID-19. The facility had two residents on droplet precautions and tested two residents for COVID-19. The results of the tests were negative.	4 000		
4 130	11-94.1-29(a) Resident abuse, neglect, and misappropriation (a) The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This Statute is not met as evidenced by: Based on record review and interview with staff members, the facility failed to implement policies	4 130		

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4 130	Continued From page 1 and procedures that prohibit mistreatment, neglect, and abuse for 1 (Resident 6) of 6 residents in the sample. The facility did not identify Resident (R)6's injuries of unknown origin; therefore, resulting in failure to implement their policy and procedures (promptly and thoroughly investigate). Findings include: R6 was initially admitted to the facility on 08/18/14. On 03/22/20, R6 was discharged for an acute hospitalization and was readmitted to the facility on 03/30/20. On 04/28/20 at 07:45 PM a review of the electronic health record (EHR) found a progress note dated 03/22/20 which documents two Certified Nurse Aides (CNA) thought R6 had fainted while on the commode. Subsequent progress note dated 03/22/20 notes at approximately 07:55 PM, R6 appeared pale and unresponsive, temperature was 98.1 degrees, blood pressure was 124/71, with blood glucose at 211 mg/dl. Per physician order, the resident was transported to an acute hospital, Emergency Department (ED). R6 was admitted to the acute facility on 03/22/20 and readmitted on 03/30/20. The discharge diagnoses included: metabolic encephalopathy due to acute urinary tract infection, dehydration and acute ischemic stroke. A review of the Nursing Admission Screening History, dated 03/20/20 found upon assessment, R6 documented with the following skin conditions: dry, red scratch marks to the chest; redness to the left and right parietal areas; fading bruise to the abdominal area; right upper extremity with	4 130	Hale Ho Aloha is committed to ensure that the facility will implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property. R6-review of resident's medical record was conducted on 4/30/20, including the Nursing Admission Screening History dated 3/30/20, nursing progress notes as of 3/30/20 at 02:51 pm, comprehensive assessment and plan of care to ensure that all findings were addressed to ensure the provision of quality care and services are provided to resident. No other residents were identified with similar conditions or issues. Training of all nursing staff was conducted on documentation of assessments, observations, statements made by resident and all follow-up action taken to ensure accurate and timely information is documented. Training of all staff was also conducted on the importance of: 1. Identifying and reporting any findings of injury, including discoloration and breaks in skin, pain, injuries of unknown origin and events that resident(s) voice as relating to identified changes in	4/30/2020 4/30/2020 5/11/20-5/22/20 5/11/20-5/22/20 and on-going

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4 130	Continued From page 2 bruises, ecchymosis and some swelling; and right lower leg with 4 cm x 2 cm bruise. The progress note dated 03/20/20 at 02:51 PM notes R6 stated "The staff at the other place hit my head with the machine they used to transfer me". Also noted, resident is "(+) pain to area and with limited mobility". R6 also denied itchiness. The weekly skin assessment prior to R6's discharge to the acute facility, dated 03/21/20 was reviewed. The resident's skin was not documented with bruises, ecchymosis, swelling, redness or bruising. A review of the physician's orders found R6 is prescribed, Plavix, 75 mg one time a day for blood thinner. The order also includes to monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, bruising, sudden change in mental status and or vital signs, shortness of breath and nose bleeds. The monthly summary dated 04/28/20 notes since readmission, R6 is more confused and forgetful with episodes of lethargy and requires total assistance with activities of daily living, except for meals. R6's food intake varies from poor to fair and requires cueing and assistance. On 04/29/29 at 01:27 PM, a telephone interview was conducted with the Social Worker (SW). R6's skin assessment on admission was reviewed with the SW. The SW responded he/she was not aware of the redness to bilateral parietal area, scratches to chest, and right upper and lower extremity bruises/ecchymosis upon R6's return to the facility. Inquired whether the resident's presentation would meet the criteria for injuries of unknown origin, the SW responded it	4 130	skin condition. 2. Review of facility P&P, requirements for event reporting to appropriate State Agencies and follow-up action needs to be taken to prevent abuse, neglect, and exploitation of residents. Training of all staff was conducted to ensure that all are informed of the Plan of Correction and expectations of staff including revisions to facility policies and procedures, and reinforcement of resident rights, prevention of abuse, neglect, and exploitation of residents. To prevent this deficient practice from recurring, the following will be implemented: 1. Conduct reviews/audits of nursing progress notes at least quarterly to ensure compliance with facility documentation standards. 2. Audits of staff competency in adherence to facility policy and procedures relating to prevention and reporting of abuse, neglect and exploitation of residents.	5/11/20-5/22/20 and on-going 5/22/20 and on-going

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4 130	Continued From page 3 probably should have been investigated; however, he/she was not aware of this. SW agreed to review R6's chart and consult with the Director of Nursing (DON). The SW was able to confirm there was no change in R6's mood or behavior. On 04/29/20 at 01:54 PM, a telephone interview was conducted with the DON. The DON reported being aware of the redness to R6's parietal area and attributed the redness to the resident's statement that he/she banged his/her head on the lift. At that time R6 was not in distress and did not have pain. The DON also recalled the resident reporting that he/she fell at the acute facility. The DON was not aware of the bruises, scratches and ecchymosis. The DON reported R6 may have sustained the injuries while at the acute facility or during transport. The Administrator provided a copy of the facility's policy and procedures for Abuse Investigations. The policy statement includes "All reports of resident abuse, neglect and injuries of an unknown source shall be promptly and thoroughly investigated".	4 130	Ongoing monitoring and evaluation will be conducted by DON and Administrator to ensure compliance with this requirement and discussed/addressed in QAPI meetings.	5/22/20 and on-going