Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125055	A. BUILDING: ______ B. WING ______	11/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HI'OLANI CARE CENTER AT KAHALA NUI	4389 MALIA STREET HONOLULU, HI 96821

(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 by the Office of Health Care Assurance (OHCA) on 10/28/20- 11/2/20. The facility was found not to be in substantial compliance with Hawaii Administrative Rules, Chapter 11-94.1. The facility census upon entrance was 9 residents.	4 000		
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 staff interviews, the facility failed to: store and serve food under sanitary conditions; maintain clean kitchen equipment; and ensure an there is an operational system for checking chemical sanitization. Findings include: 1) On 10/28/20 during the initial tour of the kitchen with the Dining Manager (DM), observed two plastic containers of red sauce stored in the refrigerator which was not covered. The sauce was labeled as "pomodoro" with "use by" date of 11/03/20. The DM acknowledged food items in the refrigerator should be covered.	4 159	In-service training of the Dining and Kitchen staff was conducted regarding the proper labeling, storage and handling of food products. Additional training was conducted regarding maintain sanitary conditions in the kitchen and with kitchen equipment. This included ensuring that equipment such as ice machines, vents and other kitchen areas are being cleaned on a regular basis and that cleaning times and dates are documented. Dishwashing procedures including keeping equipment off the floor, handled, cleaned or stored properly and ensuring that documentation of sanitizing procedures are complete and	11/15/20

Office of Health Care Assurance

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/14/20

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4 159	Continued From page 1 Observation of the ice machine found mottled black substances on the left and right wall of the ice bin. Inquired what was the black substance, the DM did not respond; however, commented the ice machine needs to be cleaned. Upon return to the kitchen on 10/30/20, the DM reported the ice machine had been cleaned. 2) On 10/29/20 during lunch service, observed a Kitchen Staff (KS)2 staff member carrying plated food on a round tray. KS2 was delivering meals to the residents. Upon return to the kitchenette, the round tray was placed atop the cover of the rubbish can. KS2 used the same tray to serve food and again placed the tray atop the rubbish can cover. Interview with KS1 confirmed the tray should not be placed on the garbage can lid, acknowledging the lid of the garbage can is not clean. KS2 instructed KS1 to get another tray and store tray on the cart between food service. 3) A follow up visit to the kitchen was done on 10/30/0/20 at 10:04 AM. Observation found four crates stored on its side directly on the floor in front of the dishwashing machine. The DM confirmed these crates are used to place the dishes/pans in to go through the dishwasher. The DM acknowledged the crates should not be stored on the floor. Concurrent observation with the DM confirmed the vents above the dishwashing area, ice machine, and reach-in refrigerator were covered with dust. 4) Concurrent observation with the DM found the facility does not have a three-compartment sink. The DM reported one of the compartments is fitted with a chemical sanitizing solution. Inquired	4 159	in sufficient detail to pass inspection. A policy and procedure was drafted to address PPM, chemical sanitization. This was shared with the staff during in-service training. Kitchen and Dining staff were in-serviced on infection control procedures including the appropriate handling of resident meal services, hand hygiene, the proper handling of plates, cups and table side service. The effectiveness of in-service training, kitchen and dining infection control will be evaluated on an ongoing basis by the dining management team. Any corrective actions with staff, including in-service training or competency checks will be documented by the dining management team. To ensure that staff performance is monitored and that interventions and solutions to issues are maintained, the Executive Chef, Director of Dining Services, Dietary Supervisor and Registered Dietitian will inspect performance and compliance logs on a weekly basis to ensure staff is following policies and procedures. Spot checking of labeling of food items, food temperatures, monitoring logs, etc. will be done weekly and a random check will be done at least once a week on a "spot check" basis in order to ensure compliance with policies, procedures or kitchen regulations as well as IPCP policies. Corrective actions regarding staff performance will be documented in the staff members file along with any retraining done. Compliance and performance to food procurement, storage, preparation and sanitation will be reviewed at the monthly	

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4 159	Continued From page 2 whether the kitchen staff keeps a log to indicate the solution is being monitored. DM answered affirmatively. A review of the log, "Sanitation Bucket Log" for the month of October, documents check marks for "AM" and "PM". There is no documentation of the test results to indicate whether the chemical concentration are at the proper levels to ensure adequate sanitization. Interview with the Registered Dietician (RD) on 10/30/20 found the facility does not have a policy and procedure for ensuring the ppm is checked for the proper chemical concentration level. On 11/02/20, the RD reported the facility has created a form for kitchen staff to record the test results of the chemical sanitizing concentration. 5) On 10/28/20 during lunch service, observed KS3 take a round tray from atop the cover of the garbage can, place the tray on the service, and put 2 plates of food on the round tray. KS3 then placed the round tray of food atop a resident's dining table, served the resident his/her lunch. KS3 placed the same round tray atop another resident's table top, served the resident lunch. KS3 returned to the kitchen area and placed the tray back onto the top of the garbage can. Interview with KS 3 confirmed the tray should not have been placed on the garbage can lid, acknowledged the garbage can lid is not clean and should have not placed the tray on the residents table when delivering plates of food. 6) On 10/28/20 during lunch service, observed KS3 touching a resident's cup and fork which the resident had been previously handling, then immediately turn and touch a cup, napkin, and spoon of a resident at another table without performing hand hygiene. In an interview, KS3 confirmed hand hygiene was not between helping the residents and should have been done.	4 159	QAPI/CQI Committee. The Director of Dining Services, Dietary Supervisor and the Executive Chef are responsible for handling ensure all staff received in-service training and will supervise dining services and kitchen cleaning procedures and infection control management.	

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4 173	11-94.1-43(a) Interdisciplinary care process (a) A comprehensive assessment shall be completed for each resident by an interdisciplinary team at least annually and updated as appropriate, based on the resident's condition. This Statute is not met as evidenced by: Based on record review and interview with staff members, the facility failed to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team for 1 (Resident 2) of 7 residents in the sample. Based on a root cause analysis staff were unable to provide documentation of a care plan revision to address the prevention of catheter-associated urinary tract infections (CAUTIs for Resident (R)2. Findings include: On the morning of 10/28/20, Resident (R)2 was observed in bed with a catheter bag hanging on the right side of the bed. A review of the facility report notes R2 has a urinary tract infection. Record review found an indwelling foley catheter was inserted on 10/09/20. R2 was diagnosed with a urinary tract infection and treated with Cipro (start date of 10/16/20) for three days which was changed to Amoxcillin (start date 10/19/20) for 8 days. Review of the lab report, indicates >100,000 cfu of Escherichia coli. Review of the Care Plan provided by the facility found no care plan update to address prevention of further CAUTIs. The care plan included	4 173	The Interdisciplinary Team under the direction of the Director of Nursing and MDS Coordinator in consultation with the attending physician, reviewed and updated the noted resident's care plan to address the issue of the prevention of further CAUTIs. In-service training was conducted with the nursing staff regarding the care planning process, root cause analysis, as well as reviewing and providing training on the management and prevention of UTIs. The MDS coordinator, Director of Nursing and Assistant Director of Nursing, the Interdisciplinary Team in consultation with the attending physician, reviewed and updated the noted resident's care plan to address the issue of the prevention of further CAUTIs. In-service training was conducted with the nursing staff regarding the care planning process, root cause analysis, as well as reviewing and providing training on the management and prevention of UTIs. The MDS coordinator, Nurse Educator, Director of Nursing and Assistant Director of Nursing will ensue that each resident's care plan is developed within seven days after completion of the comprehensive assessment, updated and that documentation is maintained in an	11/15/20

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4 173	Continued From page 4 On 11/02/20 at 10:57 AM, Registered Nurse (RN)1 was interviewed. Queried whether the facility developed a care plan for urinary tract infection (UTI) prevention for R2. RN1 referred to an episodic care plan to address the treatment of the current UTI and a care plan for foley catheter care. The MDS Coordinator (MDSC) assisted with the review. MDSC stated care plans are revised during quarterly reviews. RN1 was asked to identify interventions for prevention of UTI. RN1 responded foley catheter care every shift, urologist consult, good hand hygiene, encourage resident to drink fluids and checking to ensure no feces in the catheter (if feces present, change catheter as soon as possible). RN2 assisted in the interview. RN2 reported R2 discontinued Lasix (diuretic) and is now has fluid restrictions (1200 ml) and has diarrhea, approximately once every two weeks and is on bowel regimen for routine senna (hold for loose stools).	4 173	up-to-date manner and reflective of the care required to maintain and support the resident's quality of life. All Care plans will be reviewed and updated as required by a change in the residents condition this will be done monthly or quarterly or as needed. Documentation of that review will be noted. In-service training on the management of the care planning process will be done for nurses and CNAs on an annual basis, at the time of orientation for newly hired nurses,CNAs and all care plans will be reviewed to determine if they are complete, accurate and up-to-date. Competency checks and re-training will be done as the result of any review that determines that the care plan is not being managed as required. A twice weekly meeting is held with the Interdisciplinary team to review each resident's status, monitor their condition, any change of status and to ensure that the care plan is up-to-date. Each resident's current status is documented in a daily report. Any corrections or modifications are reviewed with the staff to ensure that issues such as UTIs, the prevention and management of UTIs, infection issues, changes in condition, etc. or other issues are addressed and that interventions are monitored and any solution, plan of action or order from the physician are carried out and sustained. The charge nurses, Director of Nursing, MDS Coordinator, Nurse Educator and Assistant Directors of Nursing monitor staff performance on a daily, weekly and ongoing basis to ensure that care plans	

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4 173	Continued From page 5	4 173	are current, interventions are updated, preventive care is ongoing and that documentation of resident care is current. Staff performance and staff competencies are monitored and documented to ensure that performance is maintained to standard and sustained over time. Staff performance issues are immediately addressed, documented and follow-up is done daily, weekly or monthly to ensure that the resident is receiving quality care. The resident, their family, staff and the attending physician are included in care planning process to ensure that all parties are heard and any modifications to the care plan are being made. Training, re-training and competency checks are done by the Nurse Educator. Documentation of staff competencies and training is maintained and is a integral part of the staff performance and evaluation process. The intent of monitoring staff competencies and each resident's status is two fold. First to ensure that each resident is receiving care appropriate for their condition, such as managing and monitoring UTIs, and to manage and monitor staff competencies overall and specifically to the individual resident care plan. In addition to care plan and staff monitoring and supervision, individual infections are tracked, interventions or modifications to a resident's care are reviewed with the medical staff and during the monthly QAPI/CQI committee meetings. The Director of Nursing, MDS RN Coordinator, Nurse Educator and the Assistant Directors of Nursing are	

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4 173	Continued From page 6	4 173	responsible for this action.	