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 |
|---|---|---|---|
| | 125047 | A. BUILDING: _____ B. WING _____ | 01/25/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HALE OLA KINO | 1314 KALAKAUA AVENUE, 2ND FLOOR HONOLULU, HI 96826 |

| (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 |
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| 4 000 | Initial Comments<br><br>A relicensure survey was conducted by the Office of Health Care Assurance (OHCA) on 01/19/21 to 01/25/21. The facility was found not to be in substantial compliance with Title 11 Chapter 94.1.<br><br>Survey Dates: 01/19/21 to 01/25/21<br><br>Survey Census: 29<br><br>Sample Size: 8 | 4 000 | | |
| 4 144 | 11-94.1-37(c) Social work services<br><br>(c) Social work services provided to each resident shall be documented in each resident's medical record and shall include but not be limited to:<br><br>(1) A social history and assessment of current social and emotional needs;<br><br>(2) A social work plan of care for each resident recorded in the medical record and integrated into the comprehensive assessment and overall care plan coordinated or integrated with other various disciplines;<br><br>(3) A discharge plan, as appropriate; and<br><br>(4) Evidence of regular review of social work services and discharge plan in conjunction with the overall plan of care.<br><br>This Statute is not met as evidenced by:<br>Based on record review and interview, the facility failed to formulate a plan of care to initiate an advance directive and document interactions with Resident (R)10 regarding follow up with her | 4 144 | * Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; | 4/1/21 |

Office of Health Care Assurance

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 02/15/21 |

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| 4 144 | Continued From page 1<br>advance directive. This deficient practice placed R10 at risk for an inability to refuse or receive medical or surgical treatment should she become incapacitated.<br><br>Finding includes:<br><br>R10 is an 88-year-old female admitted to the facility on 12/20/16 from an acute care hospital. She had diagnoses of multiple fractures sustained due to traumatic falls. A record review of R10's medical chart and electronic medical record found that she did not have an advance directive. A review of R10's care plan initially dated 12/20/16 revealed no entry by the staff indicating an objective for a follow up with her advance directive. Further review of R10's medical record, social services (SS) notes dated 01/05/17 to 12/17/20, revealed no documentation of any discussions between SS and R10 or any discussions made during care plan meetings about her advance directive. A SS note documented on 01/21/21 at 10:55 AM revealed, "SSC (social services) asked One K (independent living area where R10 previously resided) RCS if the [sic] send resident's AHCD (advanced health care directive). RCS acknowledged and will send one over after checking resident's file."<br><br>An interview was done with SS on 01/25/21 at 09:53 AM in the staff break room. He stated that his duty for advanced care planning on the resident's admission to the facility is to "look for the resident's POLST (provider orders for life sustaining treatment) and AHCD (advance health care directive)" and "discuss their goals." SS stated that he had discussions with R10 about her advance directive and did not document this in R10's medical record because she was still able to make her own decisions and would refuse | 4 144 | Upon learning of the deficient practice, the social services coordinator (SSC) reached out to the resident who then agreed to submit AHCD. The completed AHCD was subsequently filed into the physical and electronic chart.<br><br>* Address how the facility will identify other residents having the potential to be affected by the same deficient practice;<br><br>The SSC (in conjunction with the medical records professional) conducted an audit of the residents in the community who may have the potential to be affected by the same deficient practice. They found no other residents to have been affected.<br><br>* Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;<br><br>SSC will educate the resident (resident representative) upon admission as it relates to AHCD including completing the admission checklist and assessment. SSC will then review again at the quarterly careplan meetings and document in the EHR. Medical records professional will conduct an admission chart audit and report any missing AHCD and/or missing progress notes as it pertains to this topic.<br><br>* Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must | |

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| 4 144 | Continued From page 2<br>to file an advance directive.<br><br>A review of the facility's AHCD Standard Operating Procedure revised on 11/01 stated, "...Social Services will follow up with those residents who do not have advance health care directives and offer assistance to formulate any documents that the resident desires ...The interdisciplinary team will review, at a minimum, annually with the resident/responsible party his or her advance health care directives to ensure that they are still the wishes of the resident. This information will be documented in the social services notes section of the medical record."<br><br>The deficient practice of lacking a plan of care to formulate an advance directive and lacking documentation of SS services provided, resulted in an untimely follow up of the resident's advance directive. This placed the resident at risk for the inability to refuse or receive medical or surgical treatment should the resident become incapacitated. | 4 144 | be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;<br><br>Initially and for the next 30 days, the audit checklist/report shall be reviewed by the administrator to ensure compliance. The SSC and the Medical records professional shall develop a QAPI on this issue and be responsible for ongoing audits to ensure compliance. These findings (and any additional corrective actions) will be reported at the quarterly quality assurance/process improvement meetings.<br><br>* Dates when corrective action will be completed.<br>April 1 | |
| 4 203 | 11-94.1-53(a) Infection control<br><br>(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.<br><br>This Statute is not met as evidenced by:<br>Based on observation and interview, the facility failed to establish and maintain an infection prevention and control program, designed to | 4 203 | * Address how corrective action will be accomplished for those residents found to have been affected by the deficient | 4/1/21 |

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| 4 203 | Continued From page 3<br>provide a safe, sanitary, and comfortable environment to help prevent the transmission of communicable disease and infection. This deficient practice has the potential to affect the remaining 30 residents in the facility and future admissions.<br><br>Findings include:<br><br>During a concurrent observation and interview of medication administration on 01/25/21 at 8:45 AM, surveyor queried licensed nurse (LN)1 regarding Point of Care testing (POC) for blood glucose machine. LN1 verbalized he cleans the machine with PDI Sani-Cloth germicidal wipe. Queried LPN1 what is the recommended contact time for the germicidal wipe is. LN1 stated he did not know. Germicidal wipe packet was reviewed with LN1. LN1 noted the four-minute contact time for effectiveness of the wipe. | 4 203 | practice<br><br>-Upon learning of the deficient practice, licensed nurse in question received and completed re-training on the contact time for PDI Sani-cloth germicidal wipe. This was completed on 1/29/21.<br><br>* Address how the facility will identify other residents having the potential to be affected by the same deficient practice;<br><br>-There are 2 glucose monitoring machines alternately used for blood glucose monitoring for the facility. After each machine is used, it is wiped down with the PDI Sani-cloth germicidal wipe and set aside for contact time. During the time of survey- there was only 1 resident requiring accucheck procedure. NO other resident(s)affected.<br><br>* Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.<br><br>-Licensed nurses will undergo re-training on Hale Ola Kino□'s Glucose monitoring Policy and Procedure and contact time of the PDI Sani-cloth Germicidal Wipe.<br>-All Licensed staff will complete the training videos and submit attendance sheet using this website: Sparkling Surfaces - https://youtu.be/t7OH8ORr5Ig<br>-All Licensed staff will complete the CMS Nursing Home Infection Preventionist Training Course, Point-of Care Blood Testing, Module 10D. All training | |

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| 4 203 | Continued From page 4 | 4 203 | documents will be completed and submitted to OHCA by 3/22/2021.<br><br>* Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;<br><br>-Licensed staff monthly competency testing on glucose monitoring procedure will be conducted for 3 consecutive months.<br>-Root Cause Analysis (RCA) will be done with assistance from the Infection Preventionist, Quality Assurance & Performance Improvement committee and Governing Body. This RCA will be incorporated in the facility□'s infection prevention program and will be included with the facility'□s quarterly QAPI.<br><br>* Dates when corrective action will be completed.<br>-Training and Courses will be completed by March 22, 2021<br>-Competency on Glucose monitoring procedures will be completed by April 1, 2021 | |