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
	125066	A. BUILDING: ______ B. WING ______	04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KALAKAUA GARDENS	1723 KALAKAUA AVENUE 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
4 000	Initial Comments A relicensing survey was conducted by the Office of Health Care Assurance (OHCA) on 03/30/21 to 04/01/21. The facility was found not to be in substantial compliance with Title 11, Chapter 94.1, Skilled Nursing/Intermediate Care Facilities. OHCA also investigated the following Aspen Complaints/Incidents Tracking System (ACTS) #8676, #8346, #8719, and #8417. All allegations were not substantiated. Survey Dates: 03/30/21 to 04/01/21 Survey Census: 44 Sample Size: 12	4 000		
4 054	11-94.1-6(d)(1)(2) Licensing (d) The most current licensing statement of deficiencies and plan of correction shall be kept on file in the facility, and the facility shall: 1) Make the statement of deficiencies and plan of correction available for examination in a place readily accessible to residents; and (2) Post a notice of the availability of the statement of deficiencies and plan of correction. This Statute is not met as evidenced by: Based on observation and interview with staff member and residents, the facility did not ensure residents are aware the results of the state inspection are available to read and easily accessible to residents as evidenced by residents two (2) residents (Resident (R)110 and R46) were	4 054		

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4 054	Continued From page 1	4 054		

unaware of where to locate the state inspection report.

Findings Include:

Resident Council interview was done on 03/31/21 at 12:06 PM. Inquired whether residents knew where the results of the most recent State survey is located. Residents were unaware of where to find the report to review. One out of the two residents (Resident (R) 46) interviewed during Resident Council reported being blind and would not have access to the results.

On 03/31/21, observed the results of the State Agency's survey was located on the entry tables in front of the fourth and fifth floor of the elevators under two other binders (the visitor and staff sign-in binders).

Concurrent observation and interview with Social Services Director on 04/01/21 at 09:58 AM, on the fifth floor confirmed the waiting area for the elevators is not an area where residents frequent. Social Services Director further acknowledged the binder of the survey results is not easily assessable under the other binders.

Conducted a record review. R110 was newly admitted on 03/10/21. During the Resident Council interview, R110 was able to respond to this surveyors questions in a cognitive and intelligent manner. Review of R46's electronic medical record (EMR) documented an admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) on 02/24/21, she scored a 15 on the Brief Interview of Mental Status (BIMS), indicating the resident's cognition is intact. Review of Section B- Hearing, Speech, and Vision B1000. Vision- the ability to see in

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4 054	Continued From page 2 adequate light (with glasses or other visual appliances) documented R46 is severely impaired (no vision or sees only light, colors or shapes; eyes do not appear to follow objects.	4 054		
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 with staff member, the facility failed to ensure food products were stored under sanitary condition and discarded before the expiration date as evidenced by a bowl stored in an opened bag of flour and expired Thickened Cranberry Cocktail. Findings Include: On 03/30/21 at 08:25 AM, during the initial kitchen tour with Kitchen Manager (KM), the dry goods storage room had four boxes of Ready-Care Thickened Cranberry Cocktail with the use by date of 03/20/21. KM stated the items came in this morning and usually does a daily walk through to check for expired items. KM also stated dry goods should be discarded by use by	4 159		

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4 159	Continued From page 3 dates. Observation also found a bowl stored in a bag of opened flour. KM did not respond when asked if the bowl should be there and proceeded to grab the bowl from the bag of flour and walked away.	4 159		
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 observation, interview, record reviews and a family interview, the facility failed to develop a comprehensive person-centered care plan for Resident (R)15. As a result of this deficiency, the resident is at risk of negative outcomes. Findings Include 1) R56 is 91-year-old male who was admitted for hospice care on 03/05/21. On 03/31/21 at 08:26, during a family interview (FI), the family member (FM) stated she did not know if there was a hospice nurse involved. She also stated "I'm worried about his teeth. He can't swallow. He doesn't have his dentures in. I noticed during a couple of visits; his gums are not clean. It looks like his gums are a little puffy and starting to bleed. I didn't get a chance to talk to the nurses about this because my visit was over."	4 174		

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4 174	Continued From page 4 On 03/31/21 at 02:15 PM, record review (RR) revealed no care plan in the electronic medical record. RR of the Hospice binder revealed one page of notes by hospice provider of an interdisciplinary progress note. The Minimum Data Set (MDS) which entails a comprehensive, standardized assessment of each resident's functional capabilities and health needs was reviewed. The MDS stated R56 showed inflamed or bleeding gums or loose natural teeth. Furthermore, R56 had mouth or facial pain, discomfort, or difficulty with chewing. Interview on 03/31/21 at 02:20 with Unit Manager (UM) confirmed that there was no care plan and UM was apologetic. UM stated "we were working on it last week and somehow, it did not get into the system." The quality of care for R56 is compromised because there is no care plan or evidence to show collaboration between hospice, facility, and/or family member. The facility has failed to provide the fundamental principle that applies to all treatment and care for R56. This deficient practice has the potential to affect all the residents in the facility.	4 174		
4 175	11-94.1-43(c) Interdisciplinary care process (c) The overall plan of care shall be reviewed periodically by the interdisciplinary team to determine if goals have been met, if any changes are required to the overall plan of care, and as necessitated by changes in the resident's condition.	4 175		

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4 175	Continued From page 5	4 175		

This Statute is not met as evidenced by:
Based on observation, interview, record reviews and a family interview, the facility failed to implement and revise the comprehensive person-centered care plan for two resident (Resident (R)15, and R259). As a result of this deficiency, residents are at risk of negative outcomes.

Findings Include

1) R15 was admitted to the facility on 07/13/20 with diagnoses that included dementia without behavioral disturbances.

On 03/31/21 at 08:31 AM, conducted a review of R15 electronic medical record (EMR). Review of R15's care plan related to dementia documented the care plan was initiated on 07/13/20. The goals for R15's dementia included R15 will be able to communicate basic needs on a daily and the resident will maintain her current level of cognition were both initiated on 07/14/20 with a target date of 01/14/21. The only intervention was listed, to administer medications as ordered and monitor/document was initiated on 07/13/20.

On 04/01/21 at 09:33 AM, conducted an interview with the Director of Nursing (DON) regarding R15's care plan related to dementia care. The DON confirmed R15's care plan related to dementia care was not updated or revised to reflect the person-centered dementia care the resident is currently receiving.

2) The facility failed to ensure R259 was provided treatment to promote healing of a facility acquired pressure injury to the right heel.

Review of R259' s physician's order on 03/30/21,

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4 175	Continued From page 6 "Float heels and apply heel protectors while in bed every day and night shift ..." Review of wound evaluation dated on 03/29/21 the goal of care is to "Monitor/Manage" and to "Monitor for any signs of skin breakdown. Elevate heel at all times to prevent further skin breakdown." Review of R259's care plan initiated on 03/26/21 and last revised on 03/29/21, was not revised to develop interventions for healing and preventing of worsening of the pressure injury as reflected by the physician' s order on 03/30/21 and wound evaluation on 03/29/21. Observed on 03/31/21 at 08:07 AM and on 04/01/21 at 07:25 AM and 09:50 AM, R259's heels were not floating. The facility did not implement the physician' s order.	4 175		
4 197	11-94.1-46(n) Pharmaceutical services (n) Discontinued and outdated prescriptions and containers with worn, illegible, or missing labels shall be disposed of according to facility policy. This Statute is not met as evidenced by: Based on observation, interview and policy review, the facility failed to label an intravenous medication tubing in accordance with professional principles and cautionary instructions. Label did not include an expiration date for R109. Findings Include: On 03/31/21 at 10:00 AM, an intravenous (IV)	4 197		

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4 197	Continued From page 7	4 197		

antibiotic was hanging on IV pole with a medication bag labeled Ceftriaxone 2000 mg, administer 50 milliliters over 30 minutes, every 24 hours until 04/31/21.

Interview on 03/31/21 at 10:05 AM with Registered Nurse (RN)8 who confirmed that IV tubing is good for 24 hours and the label was not on tubing.

Policy review on 03/31/21 of Parenteral and IV fluids, Number 694 states The facility will provide parenteral fluids consistent with professional standards of practice, including competent staff, in consideration of the resident's plan of care, accepted infection control practices and monitoring for complications.

Interview with Director of Nursing (DON) on 04/01/21 at 11:00 whom provided policy for IV fluids. DON stated the IV tubing is good for 24 hours.

4 281 | 11-94.1-65(e)(8) Construction requirements | 4 281

(e) The facility shall have resident bedrooms that ensure the health and safety of residents:

(8) Each resident shall be provided with:

(A) A separate bed of proper size and height for the convenience of the resident and that permits an individual in a wheelchair to get in and out of bed unassisted;
(B) A comfortable mattress with impermeable mattress cover, and a pillow with an impermeable cover;
(C) Sufficient clean bed linen and blankets to meet the resident's needs;

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4 281	Continued From page 8 (D) Appropriate furniture, cabinets, and closets, accessible to and meeting individual resident's needs. Locked containers shall be available upon resident's request; and (E) An effective signal call system at the resident's bedside. This Statute is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the residents call light system is properly working and relayed in a centralized staff work area. As a result of this deficiency, residents are at potential risk for falls and/or injury. Findings Include: 1) Interview on 03/30/21 at 09:20 AM with R109 stated "I press the button and it could take 20 minutes to half an hour before they come." I told them, "Hey what you want me to do, do it in bed, walk there myself?" My main concern is someone should be there. The other day, I walked in the restroom myself. The worker came and I told them, it was too late. 2) Interview on 03/30/21 at 10:29 AM with R110 who stated it takes at least 20 minutes for the call light. I think the aide, or the nurses have eleven rooms. This morning, the call light was not working, so the nurse's aide went room to room.	4 281		