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 ______	01/28/2022

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

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4 000	Initial Comments A relicensure survey was conducted by the Office of Health Care Assurance (OHCA). The facility was not in compliance with Title 11 Chapter 94.1. Survey Dates: 01/25/22 to 01/28/22 Survey Census: 31 Sample Size: 22	4 000		
4 118	11-94.1-27(7) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (7) The right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive; □ This Statute is not met as evidenced by: Based on record review, staff interview, review of policy on Advance Health Care Directives (AHCD), and review of Resident Rights, the facility failed to ensure that a physician's code status order was consistent with Resident (R) 125's wish to not receive Cardiopulmonary Resuscitation (CPR). As a result of this deficient practice, there was the potential for R125 to receive CPR in the event of an "emergency" which was in direct conflict with the wish to not receive CPR.	4 118	1.Upon learning of the deficient practice, the resident's wishes related to advance directives have been reviewed and the health record has been updated to reflect the resident preferences. 2.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. All resident records have been reviewed to validate that the resident's physician	3/21/22

Office of Health Care Assurance

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/21/22

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4 118	Continued From page 1 Findings include: Review of the Electronic Health Record (EHR) showed R125 was admitted on 01/07/22 with a diagnosis of Cervical Spinal Stenosis, Benign Paroxysmal Vertigo, Dementia, Diabetes Mellitus Type 2, Vitamin D Deficiency, Hypertension, Gastroesophageal Reflux, Insomnia, Malignant Neoplasm of Breast. A review of R125's AHCD regarding end-of-life matters showed the following choice; to not prolong life if the situation is hopeless. Another form titled Provider Orders for Life-Sustaining Treatment (POLST) also showed the choice; Do Not Attempt Resuscitation (DNAR). However, upon review of the EHR for R125, there was a doctor's order of "Full Code" which meant that CPR was ordered in the event of an "emergency". According to R125's AHCD and POLST documents, this was not what R125 wanted. On 01/28/22 at 11:00 AM, the Director of Nursing (DON) was queried about the conflicting order. DON verified with the doctor and acknowledged that the doctor's order was wrong and should have followed R125's wish not to be resuscitated. DON stated that they will immediately make the necessary correction. A review of facility policy on AHCD stated the following: Purpose, supports a resident's right to participate in health care decision making. Through education and inquiry about advance health care directives, this facility will encourage residents to communicate their health care preferences and values. Social Services will assist the resident and/or responsible party to understand the options available. Policy, it is the policy of this facility that 1. Prior to or upon	4 118	orders and POLST reflect the resident's current preferences. 3.What measures will be put into place (or changes) to ensure that the deficient practice will not recur. The interdisciplinary team (IDT) has been re-educated regarding the resident□'s right to enact advance directives and documentation requirements. The social worker assists each resident and/or resident representative to formulate advance directives regarding end-of-life matters upon admission. A resident□s care plan which includes advance directives, physician orders and POLST, is reviewed and/or updated by the IDT on a quarterly basis, or when the residents expressed preferences may change. 4. How will the facility monitor its corrective action to ensure it doesn'□t recur? The social worker will continue to interview residents and/or resident representatives on admission to formulate advance directives. The medical records coordinator will audit admission records to validate that the resident□s' advance directives are documented in the physician orders and POLST. The medical records coordinator will track admission audit findings and submits monthly reports to the QAA Committee for further review and recommendations.	

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4 118	Continued From page 2 admission of a resident, the Resident Care Manager or Social Service Director will ask residents, and/or their family members, about the existence of any advance health care directives. 2. Should the resident indicate that he or she has issued advanced health care directives about his or her care and treatment, the facility will require that a copy of such directives be included in the medical record, and the facility will confirm that directives are current and still the desires of the resident ... 8. The facility shall comply with the written or oral declarations of a resident, or the treatment decision of his or her surrogate. If the resident's attending physician refuses to comply with the lawful declaration of the resident, or the lawful treatment decisions of his or her surrogate, the facility will assist the resident or resident's surrogate in obtaining another attending physician who is willing to carry out the wishes of the resident, or transfer the resident to another facility. 11. This facility will notify the physician of advance health care directives so that appropriate orders can be documented in the resident's medical record. 14. Inquiries concerning advance health care directives should be referred to the administrator, the resident care manager, or the social service director. A review of the Statement of Resident Rights stated the following: Resident Rights, the resident has a right to a dignified existence, is treated with respect and dignity, and receives care in a manner and in an environment that promotes maintenance or enhancement of his/her quality of life. The facility must protect and promote the rights of each resident ... Self-Determination, the facility must promote and facilitate resident self-determination through support of resident choice in various aspects of life in the facility.	4 118		

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4 148	11-94.1-39(a) Nursing services (a) Each facility shall have nursing staff sufficient in number and qualifications to meet the nursing needs of the residents. There shall be at least one registered nurse at work full-time on the day shift, for eight consecutive hours, seven days a week, and at least one licensed nurse at work on the evening and night shifts, unless otherwise determined by the department. This Statute is not met as evidenced by: Based on observations. Interviews and record reviews, the facility failed to provide timely toileting needs for Resident (R) 15. This deficient practice has the potential to affect other residents who require toileting needs and has a risk for Urinary Tract infections (UTI). Findings include: Record review (RR) done on 01/26/22 at 2:58 PM shows R15 was prescribed doxycycline 100 mg tablets on 11/22/21 for a UTI. Observation on 01/27/22 at 07:15 AM of R15 in her room sleeping. Pillow tucked to right side, off loaded to the left with pillows under her knees. Observation on 01/27/22 at 0758 AM, still lying-in bed, same position as 07:15 AM. Observation on 01/27/22 at 08:42 AM, R15's breakfast arrived. She was pulled up with two nurse's assistants. Observation on 01/27/22 at 09:00 AM and a concurrent interview with certified nursing assistant (CNA)2 was done. Query with CNA2	4 148	1.Upon learning of deficient practice, what corrective action was done. -Immediate coaching and re-education provided to the 2 CNAs who were in the room at 8:42am for what could have been an anticipated toileting opportunity for the resident which could have shorten resident□s wait time. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. -A list was generated of all residents with a care plan requiring anticipation of toileting needs. Residents who scored 9 or less in the Bowel and Bladder Assessment who are considered poor candidates to receive bladder training. -Re-Educated all staff at an awareness meeting on all shifts addressing anticipation of toileting needs of all residents on the list. 3. What measures will be put into place (or changes) to ensure that the deficient practice will not recur. -Morning rounds, including toileting program during the busy hours of meals service was reviewed, organized, and	3/21/22

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4 148	Continued From page 4 regarding intake of breakfast was made. CNA2 stated that she had poor intake and fluids were 40 ml and she ate 20% of her meal. Observation of the R15 reveals that the resident appeared uncomfortable and is making a noticeable moaning sound. Observation on 01/27/22 at 09:50 AM revealed that R15's brief had not been changed yet. Observation on 01/27/22 at 10:00 AM, CNA2 came into the room. R15 demonstrating distress with increased moaning, louder than earlier and at a quicker pace. This surveyor queried with CNA2 if R15 had any problems with breathing and why is she making a loud moaning sound? Does she need to go shi shi (urinate) and R15 responded clearly "shi shi"to surveyor and CNA. R15 continued to moan loudly. As CNA2 began to get R15 up, she continued to moan louder. R15 was taken to the restroom by wheelchair. CNA2 stated that she hardly goes in her diaper, she goes in the toilet. R15 immediately urinated when seated on the toilet. R15 stopped moaning after urinating. She was able to sigh in relief as she looked at surveyor. At that time, CNA1 arrived. Upon query with CNA1, who stated that resident was taken to the restroom at the last time of 6:30 this AM, 3.5 hours ago. CNA2 showed surveyor that the brief was dry. RR shows resident's care plan for alteration in skin integrity with interventions of "anticipate toileting needs - keep resident dry." Care plan for at risk for infection, interventions include monitor for urgency and frequency of urination; monitor for abdominal pain or discomfort, foul smelly urine, decreased urine output, fever, bloody urine, concentrated urine output.	4 148	restructured increasing planned opportunities to toileting residents while staff are already in the room serving in-room dining. Nurses will be re-educated to identify needs through observation and offer toileting as needed during in-room visits. 4. How will the facility monitor its corrective action to ensure it doesn□t recur? -All nurses will be re-trained on the anticipation of toileting need revised program by March 1, 2022. -Random floor observation will be conducted by nurse managers daily for 3 months. -ADL audits on toileting will also be done on target residents weekly for 3 months by the QA nurse.	

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4 148		4 148		

Continued From page 5

Interview on 01/27/22 at 12:36 PM Registered Nurse (RN)1, was performed. RN1 was asked how they train their staff regarding a bladder program? RN1 stated that we just tell the CNAS that the resident is on a bladder training program.

In an interview with the Director of Nursing (DON) on 01/27/22 at 1:00 PM, the DON was queried regarding a bladder program guidelines or protocol. DON stated that "there is a general rule for our CNAs to document. When the residents come, we don't know if the residents are continent or incontinent. We identify their pattern. When we identify their pattern, we train them in that pattern. We do not have any guidelines that say every two hours or a time-based guideline.

Observation was shared with the DON regarding toileting of R15. DON stated that she created the morning routine for the nurses' aides. Breakfast rounds is at 07:15 AM. Everyone does their rounds and takes care of their own toileting from first rounds. At 7:15 AM, everyone does the dining, and we serve as able. There is a runner for A side. C side distributes the meals in the rooms simultaneously. After dining is done, we are all facing a one to one. Although the nursing assignment shows CNA1 assigned to R15's room (212A); CNA1 was also assigned to the dining room at breakfast rounds said the DON.

This surveyor queried the DON regarding what urgency means - DON stated that it means they can call when they want to go to the bathroom. The DON confirmed that R15 could not use the call bell. R15 waited 3.5 hours to use the toilet and was moaning in distress and could not use the call bell. DON concluded that an assessment for an adaptive call bell for R15 would be initiated.

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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, staff interview and review of policy, the facility failed to label three food containers and properly store eighteen (18) tomatoes that was in the refrigerator located outside the unit's food pantry. Findings include: On 01/25/22 at 09:40 AM, during an observation of the refrigerator located outside the unit's food pantry, three food containers which contained fruits, rice, and meats were not labeled with dates. Also, 18 tomatoes were noted on the top shelf of the door and was open to air and not in any container. A sign was posted on the refrigerator door which stated the following: Stop, attention all families and residents, is your food labeled and dated? All food that is not properly labeled and dated will be thrown away! All food more than 3 days old will be thrown away. On 01/25/22 at 10:00 AM, the Administrator (Admin) was queried about the observations as	4 159	For purposes of this F812, the staff member was unable to place her lunch into the employee breakroom refrigerator due to the surveyors utilizing the room, so she placed it inside this refrigerator located outside the unit's food pantry. It is not a refrigerator the staff use for their personal items, but did so due to the above-mentioned situation. 1. Upon learning of the deficient practice, the food was immediately removed from the refrigerator. No residents were identified as having been affected. 2. 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, however, due to the pandemic, this resident refrigerator has not been utilized.	3/11/22

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4 159	Continued From page 7 previously stated. Admin stated that the refrigerator was used for food that was brought (from outside the facility) for the residents. Admin acknowledged that the three food containers and the 18 tomatoes should have been properly labeled and/or properly stored. Admin proceeded and immediately removed the three containers and tomatoes from the refrigerator. A review of the facility policy on Use and Storage of Food and Beverage stated: Policy, it is the policy of this community to provide safe and sanitary storage, handling, and consumption of all food including food and fluids brought to residents by family and other visitors. Procedure, c. Monitor, Community staff will be appointed to check resident refrigerator for proper temperatures, food containment and quality, and disposal of items per community policy. Community staff will be appointed to check resident rooms through daily housekeeping process for food and beverage items for safe and sanitary storage and handling. Foods requiring refrigeration will be received by the community designee (activity department, food and nutrition department, charge nurse, etc.) for proper and immediate storage including labeling and dating. Staff will examine food for quality (smell, packaging, appearance) to identify potential concerns. If concerns are identified, staff will notify the resident or resident representative of findings and necessary actions per proper food and beverage safe handling.	4 159	3. What measures will be put into place (or changes) to ensure that the deficient practice will not recur. All staff will be re-educated at a nutritional education session on February 22 regarding labeling and proper storage. Housekeeping team will be re-educated on daily monitoring to include removal of undated or outdated food. 4. How will the facility monitor its corrective action to ensure it doesn't recur: Housekeeping team will continue its daily check and monitoring. The dietary supervisor will conduct random checks to ensure compliance and include reports in QAA Committee meeting for further review and recommendations.	
4 204	11-94.1-53(b)(1) Infection control (b) The facility shall have provisions for isolating residents with infectious diseases until appropriate transfers can be made.	4 204		3/12/22

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4 204	Continued From page 8 (1) The facility shall have a written policy that outlines proper isolation and infection control techniques and practices; This Statute is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to follow appropriate infection control procedures when 1) licensed practical nurse (LPN)5 brought in a multi-use container of glucometer strips, used to check R175's blood sugar, into R175's isolation room; 2)the facility practice of sharing face shields instead of dedicating face shields to one Health Care Professional was not in compliance. These deficient practices place all residents at risk for the potential spread of infection and/or spread of communicable diseases. Findings include: 1) On 01/27/22 at 11:17 AM, a concurrent observation and interview were done with LPN5 who was going to do R175's scheduled blood glucose check. LPN5 prepared her supplies at her medication cart in the hallway. She stated that the glucometer and associated supplies were used facility wide to check any residents needing blood sugar checks and that there were no separate supplies for residents in isolation. She placed the glucometer (machine to check blood glucose), a bottle of glucometer strips, a piece of two by two gauze, an alcohol prep pad, a lancet (used to prick the finger to obtain blood) and a plastic medication cup on top of a small plastic tray. She carried the tray to the outside of R175's room where there were signs indicating that it was an isolation room. There was a plastic bin with drawers containing yellow gowns (LPN5	4 204	Multi-Use Glucose Strips: 1. Upon learning of the deficient practice, what corrective action was done: The licensed nurse in question received and completed reeducation on the glucose monitoring including handling and storing of glucose strips. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: During the time of survey there were 3 residents affected (3 residents on accucheck, 2 in green zone and 1 in the yellow zone.) There are 2 glucose monitoring kits and each kit has a designated glucose strips bottle. 3. What measures will be put in place (or changes) to ensure that the deficient practice will not recur: Isolation rooms will have a designated glucose monitoring kit (glucometer, glucose strips bottle, lancets, alcohol swabs, band aid, PDI cloth and glucose control). The kit will be mainly used for isolation room. A glucose strip bottle will not be brought into the isolation room; instead a strip will be taken out from the bottle to be placed in a med cup and covered. That strip in the med cup together with the glucometer, alcohol swab, band aide and gauze, PDI will be placed on tray to use in the isolation room.	

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placed her tray on here), a sign indicating that personal protective equipment (PPE; gloves, gown, faceshield) needed to be put on before entering the room, plastic faceshield hanging on hooks on the wall to the left of the doorway, to the right of the doorway there were two black covered bins one to collect trash and another to dispose of the re-usable gowns and a tray holding two containers of disinfecting wipes. LPN5 donned her PPE and proceeded into the room. R175 was sitting up in a wheelchair with the bedside table high across her lap. She placed the plastic tray of supplies unto R175's bedside table. LPN5 proceeded to check R175's blood sugar. She wiped R175's finger with the alcohol prep pad, pricked her finger with the lancet and wearing the same gloves, opened the bottle of glucometer strips, took one strip out, replaced the cap unto the container of glucometer strips, and placed the strip unto the glucometer. LPN5 had to squeeze R175's finger to obtain a blood sample. After R175's blood sugar check, LPN5 placed the tray holding the glucometer and bottle of glucometer strips unto the tray holding the two containers of disinfecting wipes, outside of the room. She removed her PPE and disinfected the supplies.

At 12:00 PM, an interview with LPN5 was conducted in the hallway at her medication cart. She stated that she was supposed to have removed a glucometer strip from the container and placed it into the medication cup, instead of bringing in the container of glucometer strips into R175's room, to avoid cross contamination of the bottle of glucometer strips.

On 01/28/22 at 11:33 AM, the Director of Nurses (DON) and Infection Preventionist nurse (IPN) were interviewed in the DON's office. The IPN stated that multi-use containers, like lotion, would

All reusable equipment will be decontaminated after use.

All Licensed staff will complete glucose monitoring/handling and storing strips training. All Licensed nurses will complete CMS videos assigned. All training documents will be completed and submitted.

4. How will the facility monitor its corrective action to ensure it doesn't recur: Licensed staff will undergo monthly competency testing on glucose monitoring/ handling and storing glucose strips will be conducted for 3 consecutive months. Competency will be completed by April. Infection Preventionist will include reports in QAA Committee for further review and recommendations.

Use of Face Shields:
1. Upon learning of the deficient practice, what corrective action was done: all staff attending the isolation rooms were identified and a designated face shield was given.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice: All staff will have a designated face shield labeled with their name that they can use when going into an isolation room. Face shields will be decontaminated after each use and will be stored and hung in a designated area.

3. What measures will be put in place (or changes) to ensure that the deficient

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4 204	Continued From page 10 not be brought into a resident's isolation room and therefore the container of glucometer strips should not have been brought into R175's room by LPN5. 2) Observation and concurrent interview were made on 01/25/22 at 09:00 AM outside of Room 220 where face shields were hung outside of door on the wall. Query was made with the Director of Nursing (DON) who stated that shields are used by all staff to go into the room. The shield must be cleaned and hung up outside room. It was not known how long the face shields would stay up on the wall before being replaced. Observation of physical therapist in room with face shield and no goggles on. Interview with Infection Preventionist nurse (IPN) was done on 01/25/22 at 0930 and IPN showed this surveyor the facilities process of cleaning the face shields outside of the rooms. This surveyor shared with IPN that there was a concern regarding sharing face shields. On 01/25/22 at 10:43 AM, research of the Centers for Disease Control and Prevention (CDC) website was done regarding personal protective equipment (PPE) and eye protection was done. (2019). CDC, 2019 states that "In areas of substantial to high transmission in which Health Care Provider (HCP) are using eye protection for all patient encounters, extended use of eye protection may be considered as a conventional strategy. Pertaining to practice in the facility, CDC, 2019 goes on to say that "Eye protection should be removed, cleaned, and disinfected, it should be dedicated to one HCP and cleaned and disinfected whenever it is visibly soiled or removed (E.g., when leaving isolation	4 204	practice will not recur: Face shields will be changed every week provided integrity remains intact and visibility is not compromised. All staff will complete training on face shield use, decontamination and storage after each use and submit attendance. 4. How will the facility monitor its corrective action to ensure it doesn't recur: - Random floor observation will be conducted by infection preventionist. The infection preventionist will track and audit compliance and submit reports to the QAA Committee for further review and recommendations. The DPOC will be completed and submitted, along with copies of the completed/signed training courses on or before the due date of March 12, 2022.	

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 ______	01/28/2022

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

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4 204	Continued From page 11 area) prior to putting it back on. Record Review (RR) on 01/28/22 shows the Positivity Rate Reporting period from December 27 through January 2, 2022 with the positivity rate at 17.27% and community transmission reported at high. Interview on 01/28/22 at 11:33 AM with the DON and IPN in the DON's office, the DON stated that the facility's use of PPE was not being used in the contingency nor crisis capacity.	4 204		