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 ______	03/17/2022

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 re-licensure survey was conducted by the Office of Healthcare Assurance (OHCA) on 03/17/2022. The facility was found not to be in compliance with Hawaii Administrative Rules, Title 11, Chapter 94.1 Nursing Facilities. Census: 45 Residents	4 000	Hale Ho Aloha is committed to ensure that food is stored, prepared. and served under sanitary conditions. 019-Sanitation Policy and Procedure was reviewed and revised to include the proper process for labeling all perishable food items by using two dates to indicate the date the product was initially opened and secondly indicating the date by which the item must be discarded (ie. 5/1/22-5/7/22). Established guidelines for safe consumption of food items which include when the items need to be discarded. Guidelines for labeling and safe consumption will be posted on dietary bulletin board for easy access for review at all times and as needed.	4/20/2022
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, interviews, and record reviews, the facility failed to ensure perishable food were stored was not expired and safe for consumption. As a result of this deficiency, residents are at risk of adverse physical reaction to ingesting potentially spoiled food and beverage items. Findings include: On 03/16/22 at 09:20 AM, conducted an observation and concurrent interview with Dietary Staff (DS)1 of the facility kitchen. One large open can of oyster sauce and one large open can of	4 159	Training of all dietary staff will be conducted on 4/22/22 by Dietary Manager on: 1. Importance of ensuring that food is stored, prepared, and served under sanitary conditions. 2. The proper labeling of food indicating date opened and date by when food is to be consumed and/or discarded using guidelines noted above. 3. To ensure all staff are informed of the Plan of Correction and expectations of staff, including a review of revisions made to policies and procedures, and reinforcement of maintaining sanitation to ensure quality standards. 4. Pre and post tests will be conducted to determine staff competency and reviewed with staff. To prevent this deficient practice from recurring, on-going audits will be conducted by the Dietary Manager to determine staff competency and adherence to sanitary food practices. Staff counseling may be conducted to ensure compliance, as necessary.	4/22/2022 4/22/2022 and on-going

Office of Health Care Assurance

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	04/20/2022

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4 159	Continued From page 1 hoisin sauce was inspected and found the sauce cans were not labeled properly. The large can of oyster sauce had a sticker label (dated 06/30/21), was approximately two-thirds full, and sauce was dried along the rim of the can making it difficult to open. The large bottle of hoisin sauce had a sticker label (dated 11/03/21) and a piece of masking tape with a handwritten date (11/23/21). The can was approximately one-third full and had dried sauce along the rim of the can that make it difficult to open. Both cans had a strong metallic smell when the sauce cans were opened. Inquired with DS1 regarding how can good are dated after opening and after opening how long are items good for. DS1 stated the sticker label indicated the date the item was received as inventory, a handwritten date indicates the date opened, and once opened the sauces would be good for three to five days. DS1 also confirmed the large can of hoisin sauce was expired and should have been discarded. DS1 also confirmed that it is unknown when the can of oyster sauce was opened and was unable to ensure the sauce was not expired. On 03/17/22 at 10:45 AM, conducted a review of the facility's Food Receiving and Storage policy and procedure (P&P) which documented "7. All food stored in the refrigerator or freezer will be.......labeled, and dated." Requested the facility's P&P which documents how long foods are kept after opening. The policies and procedures received did not provide the timeframe foods were safe to use after opening.	4 159	On-going monitoring and evaluation will be conducted by the Dietary Manager with support of the DON and/or Administrator to ensure compliance with this requirement and discussed/ addressed in QAPI meeting.	4/22/2022 and on-going
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	4 175	Hale Ho Aloha is committed to ensure that changes to a resident's overall plan of care are conducted as needed to address a resident's pain and comfort level.	

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4 175	Continued From page 2 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. This Statute is not met as evidenced by: Based on interviews and record review, the facility failed to ensure changes to one resident's (Resident (R)1) overall plan of care (POC) to address the resident's pain. Findings include: R1 was admitted to the facility on 03/10/21 with diagnosis that includes a stroke, high blood pressure, type 2 Diabetes, urinary retention, a supra pubic catheter, and a history of lower back and left knee pain. On 03/15/22 at 10:55 AM conducted an interview with R1. R1 reported having chronic back pain and stated that he/she does not like to take medication to alleviate the chronic pain but that was the only approach to pain relief the facility has consistently offered. R1 stated that once the facility provided a warm wet towel to put on his/her back, but it made the bedding and resident wet which was uncomfortable. Inquired if the facility repositioned him/her to alleviate pressure to the resident's back or offer the resident a warm compress (water bottle or warming packets) that could safely provide warm therapy for pain. R1 confirmed that the facility has focused on medications as the primary means to address his/her chronic pain. R1 stated that he/she does not like to take medications because it upsets his/her stomach and does not provide much relief and the medication.	4 175	Resident 1-Care plan was reviewed and revised to incorporate pain management using non-pharmacological interventions consistent with facility policy "Pain Assessment and Management."	4/20/2022
			Care plans of all residents under pain management were reviewed and revised to ensure that non-pharmacological interventions are addressed and incorporated in the respective care plans.	4/20/2022
			Review of facility policy/procedures for development of care plans was also conducted and revised to require that all RNs henceforth will initiate a plan of care and/or revise care plans as changes occur/are noted with residents. When revisions are made, RNs will ensure that all staff are notified of changes so that appropriate resident care is provided immediately and to ensure that resident's needs are addressed timely and effectively.	4/20/2022
			Training of all nursing staff will be conducted on 4/22/22 by the DON on the following: 1. Procedural changes for the development of plans of care. 2. Review and revision of policy "Pain Assessment and Management" to ensure that pharmacological and non-pharmacological interventions are included in care plans to ensure maximum resident comfort and on-going monitoring, evaluation, and documentation of resident outcomes to interventions. 3. New staff will receive in-service education during orientation on the importance of pain management and the use of pharmacological and non-pharmacological interventions. 4. Pre and post tests will be conducted to determine staff competency and reviewed with staff.	4/22/2022 and on-going

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4 175	Continued From page 3 On 03/16/22 at 3:45 PM, conducted a record review of R1's electronic medical record (EMR). A review R1's POC related to pain documented R1 has chronic pain related to having had a stroke, myocardial infarction (heart attack), congestive heart failure, anemia, and disease process (Basal cell carcinoma of the right upper back and left neck) which was initiated on 03/10/2021 and revised on 12/07/21. There are twelve (12) interventions listed were initiated on 03/10/21 and revised on 03/21/21 (date of admission: 3/10/21). There was only one intervention listed on R1's POC that addressed symptom relief which was to administer analgesia (Tylenol) as per orders. Give 1/2 hour before treatment or care. The other interventions were to anticipate the resident's need, monitor, document, report, notify the physician, observe, and report changes, and report any changes in activities to the nurse. Review of physician orders documented an order for Acetaminophen 650 mg (by mouth and suppository) every four hours for mild pain was initiated on admission (03/10/21). A physician's order for Baclofen was started on 01/20/22 and discontinued on 02/10/22. Review of the Medication Administration Record (MAR) documented R1 was administered one dose of Baclofen 5 mg once (01/14/22) during the 21 days the order was active. There was no documentation as to how the facility would manage severe or moderate pain for R1 and there were no non-pharmacological pain management interventions. On 03/17/22 at 09:35 AM, conducted a concurrent record review and interview with the Director of Nursing (DON) regarding R1's overall POC for pain. The DON confirmed there were no interventions to address severe/moderate pain or	4 175	To prevent this deficient practice from recurring, on-going audits will be conducted by the DON/ designee to ensure that non-pharmacological management interventions are identified in the resident care plans, staff are aware of the importance of assuring resident comfort, and appropriate changes are made to address interventions that work well in maximizing resident comfort. Training of all staff will be conducted to ensure all are informed of the plan of correction, policy and process changes made, and expectations of staff in areas identified as non-compliant. On-going monitoring and evaluations will be conducted by DON/designee by review of audits and monitor to identify patterns/trends, and recommend adjustments to the plan of care and/or care planning process as needed to ensure compliance with this requirement and discussed/addressed in QAPI meetings.	4/22/2022 and on-going 4/22/2022 and on-going 4/22/2022 and on-going

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4 175	Continued From page 4 non-pharmacological pain management interventions and there should have been. The DON also confirmed that R1's pain goes unrelieved due to the resident's choice to not take pain medication for pain symptoms.	4 175		
4 203	11-94.1-53(a) Infection control (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. This Statute is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure infection control interventions were implemented as evident by staff not wearing the required personal protective equipment (PPE) to minimize and prevent resident's exposure to COVID. As a result of this deficiency, residents are at an increased risk of exposure to COVID. Findings include: 1) On 03/16/21 at 2:15 PM, observed Facility Staff (FS)1 seated outside of the activities room doorway not wearing a face shield or face mask, eating chips. Resident (R)2 was seated perpendicular to FS1, leaning forward, holding an empty plastic cup, reaching on the floor trying to pick chips (same type of chips FS1 was eating) off of the floor near the resident's feet. When FS1 saw this surveyor, he/she stopped eating then looked over to R2 and realized the resident	4 203	Hale Ho Aloha is committed to ensure the maintenance of a safe, sanitary, and comfortable environment and to help prevent the development and spread of disease and infection. Nursing personnel were provided re-training on the importance of proper hand hygiene using either hand sanitizer or handwashing; proper use of PPE, and the importance/purpose of PPE use as related to transmission-based precautions and the facility's overall infection prevention and control practices in Feb 2022. Donning and doffing of PPE was also discussed and reviewed. DON will provide retraining on 4/21/22 with review of facility policy and procedure of PPE use, including donning and doffing of PPE, importance of appropriate use of PPE to prevent the spread of infection to residents, resident families, and staff (including staff family members) and community at large, and have staff demonstrate proper donning and doffing of PPE. Review of facility policy regarding staff expectations and roles were reviewed with staff to ensure that staff maintain resident dignity throughout the performance of their care. Staff were informed that removing their mask and eating in front of/with a resident is not allowed and may pose a risk to resident by not maintaining facility policy of face coverings during the provision of care to residents. Staff member in question was counseled.	4/21/2022-4/28/2022 4/20/2022

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4 203	Continued From page 5 was trying to pick chips off the floor. FS1 (still with no face shield or mask) walked across the main dining room (located immediately outside of the activities room), got a broom and a long-handled dustpan to sweep the chips off the floor. On 03/17/22 at 09:30 AM, conducted an interview with the Director of Nursing (DON). The DON confirmed that staff should be wearing a face shield and face mask while in proximity of residents. The DON stated that staff should not be eating in front of residents and the facility has designated staff dining areas. 2) On 03/15/22 at 08:30 AM, an initial query was made with the DON regarding the type of PPEs staff is required to use for the nursing units. DON stated that direct patient care (DPC) staff on the nursing units were to wear a face mask and face shield. On 03/15/22 at 08:45 AM, DPC2 was observed to be providing care to residents wearing her eyeglasses and face mask on a nursing unit. On 03/15/22 at 12:55 PM, DPC3, who was seen previously on the nursing unit providing resident care wearing her eyeglasses and face mask, was now wearing a face shield with her face mask. On 03/16/22 at 10:49 AM, DPC4 was in the activity room with residents wearing only her face mask. On 03/17/22 at 10:07 AM, a concurrent observation and interview of DPC5 was done. DPC5 was donning personal PPEs before entering a resident's room, who is on contact and droplet precautions. DPC5 stated that she was checking resident vital signs (blood pressure,	4 203	To prevent this deficient practice from recurring: 1. On-going audits of staff competency will be conducted by the DON/designee to ensure adherence to infection control practices, especially as relating to appropriate/proper use of PPE, sanitizing equipment, and items used during the course of conducting nursing duties. Staff identified not to be in compliance will be retrained, counseled, and disciplinary action taken, as appropriate. 2. Diagrams of donning and doffing of PPE will be posted on staff bulletin boards and on resident door during isolation for reference. 3. Staff unable to comply to PPE requirements, are to inform their supervisor and will not be allowed to enter areas on transmission-based precautions until PPE requirements are met. 4. Adequate PPE supplies will be ordered and always maintained. Training of all staff will be conducted to ensure all are informed of the plan of correction, policy and procedural changes made and expectations of staff in areas identified as non-compliant. On-going monitoring and evaluation will be conducted by DON to ensure compliance with this requirement and addressed/discussed in QAPI meetings.	4/21/2022 and on-going 4/21/2022 and on-going 4/21/2022 and on-going

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4 203	Continued From page 6 pulse, temperature, respiratory rate). She was wearing eyeglasses, gown, and gloves. When queried if she is required to wear a face shield, she stated she is supposed to wear one, but misplaced it. On 03/17/22 at 10:19 AM, DON was interviewed in the conference room. She stated that DPC staff are required to wear a face mask and face shield while on the nursing units. DON further stated that eyeglasses are not an acceptable form of eye protection, and that DPC staff are supposed to wear their face shield over their eyeglasses.	4 203		