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
	125057	A. BUILDING: ______ B. WING ______	07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULANA MALAMA	**91-1360 KARAYAN STREET EWA BEACH, HI 96706**

(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-licensing survey was conducted by the Office of Healthcare Assurance (OHCA) on 07/15/22. The facility was found not to be in substantial compliance with Hawaii Administrative Rules (HAR) Tiltle 11 chapter 94.1. The following Aspen Complaints/Incidents Tracking System (ACTS) were investigated: ACTS #9109 was substantiated and #9376 was not substantiated. Survey Dates: 07/12/22-07/15/22 Survey Census: 29 Sample Size: 12	4 000		
4 115	11-94.1-27(4) 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: (4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility; This Statute is not met as evidenced by: Based on interviews and record review, the facility failed to promote quality of life for Resident (R)2 by ensuring he was treated with dignity and	4 115	CNA 5's employment was terminated at the close of the investigation in September 2021.	8/26/22

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4 115	Continued From page 1 respect when a staff member provided personal care. This deficient practice has the potential to affect all residents in the facility who receive assistance with personal care. Findings Include: R2 was admitted to the facility on 12/03/08. R2's diagnoses included severe intellectual disabilities, unspecified abnormal involuntary movement, abnormal reflex, unspecified paraplegia, unspecified scoliosis, and unspecified hip disorder of ligament. Review of R2's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/22/22 documented R2's cognitive skills for daily decision making as severely impaired. On 09/28/21 the facility submitted a completed Event Report to the State Agency. The Event Report documented "On 09/22/21, at approximately 7 pm, it was reported by a witness [Registered Nurse (RN) 38] that... [Certified Nursing Assistant (CNA) 5] ...was heard yelling at the resident, "This is why I get hurt, you bitch!" She was also heard yelling profanities...in the resident room and slapping the resident's inner thigh with excessive force...The witness immediately pulled ...[CNA5] ...aside and spoke to her about treatment of the resident [R2]." It was reported that CNA5 was frustrated with the resident because both of her wrists were hurting due to arthritis. On 07/14/22 at 10:05 AM interview with Registered Nurse (RN) 30 was done. RN30 stated she worked on 09/22/21 and was the oncoming night shift. RN30 did not witness the	4 115	The facility failed to report the possible abuse to the State of Hawaii, Department of Human Services, Adult Protective Services (APS) in a timely manner. A report was filed with the State of Hawaii, Department of Health, Office of Health Care Assurance (OHCA) per requirements; however, the report was not sent to APS. After being notified of our error, a report was submitted to APS on July 19, 2022. On July 21, 2022, APS case managers visited the facility to review the resident chart to determine their further actions. No other resident since that incident has had an event which could have been the result of potential abuse. The facility will comply as required to submit reports to the appropriate government agencies as necessary. Management and staff will be in-serviced on August 19, 2022, by the Social Services Director and Director of Nursing on the reporting requirements for events, including when it is necessary to report to OHCA and APS. The Administrator will be responsible for ensuring that the reports are sent to OHCA and APS in a timely manner as the Administrator is the last to review all reports prior to submission to appropriate agencies. All staff will be in-serviced by the Director of Nursing and Social Services Director on August 26, 2022 concerning Resident	

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4 115	Continued From page 2 incident but was with the charge nurse when CNA5 stated she wanted to go home and reportedly asked RN38 to help change R2 because he made a bowel movement (BM) and was not cooperating. RN30 reported CNA5 felt disrespected by RN38 and explained RN38 told her she was inappropriate and unprofessional. RN30 reported CNA5 blamed R2 for her sore wrists. RN30 spoke with RN38 and RN38 reported she went to help CNA5 and witnessed CNA5 swear in front of the resident, was rough when changing the resident's diaper, and blamed the resident for her wrist injury in front of the resident. RN30 reported she was instructed by the charge nurse to check on R2 and to examine his skin for signs of physical abuse. RN30 stated she did not see any redness, bruising, or scratches and the resident did not appear to be in any discomfort. RN30 further described R2 usually cooperative when providing care but becomes anxious when there is more than one person in the room and can become uncooperative. RN30 stated "you have to be patient and talk to him nicely." RN30 described CNA5 as a "good" CNA but " ...can't say I agree with her methods. She can be a bit more rough." Inquired with RN30 the impact if a reasonable person was in a similar situation, RN30 stated " ...they [the resident] wouldn't feel very well. They would feel bad as if it was their fault." On 07/14/22 at 10:05 AM interview with CNA1 was done. CNA1 did not work on the day of the incident but has experience working with R2. CNA1 explained R2 is uncooperative if there is more than one person in the room providing care and " ...if I change him, I talk to him nice he will listen ...he will eventually calm down and participate." CNA1 further explained if R2 is rushed he won't listen and become	4 115	Rights and abuse prohibition and protocols. For those not able to attend, a handout and post-test will be given. Periodic, random audits will be done by the Director of Nursing, Assistant Director of Nursing and Social Services Director watching staff interactions with residents. This will be done weekly x 3 months, then bi-monthly x 3 months. Any discrepancies will be reported to the quarterly QA/QI Committee meetings by the Social Services Director.	

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4 115	Continued From page 3	4 115		

uncooperative. CNA1 confirmed CNA5's technique can be rough when assisting residents but has not noticed residents in pain or hurt due to her technique.

On 07/14/22 at 11:17 AM telephone interview with RN38 was done. RN38 confirmed she witnessed the incident on 09/22/21. RN38 reported she assisted CNA5 in changing R2 after having a BM. RN38 reported CNA5 appeared to be frustrated that day and was rough when providing care, tossing R2 side to side aggressively than normal, slapping his thighs, grabbing and pulling him toward her, and reportedly said "This is why I get hurt, you bitch." RN38 reported CNA5 then said " ...he knows I am just playing with him, I raised him." RN38 described R2 as a "sweet boy" and " ...if you talk sweet to him and hold his hand ..." to distract him from scratching his buttocks, he usually cooperates.

On 07/14/22 at 01:36 PM interview with RN29 was done. RN29 stated she was working as a CNA on 09/22/21 but did not witness the incident. RN29 stated if you are patient and speak calmly when providing care to R2 he will listen to you. RN29 further stated if R2 made BM, holding his hand prevents him from touching his buttocks, " ...he loves holding hands."

On 07/15/22 at 10:26 AM interview with Director of Nursing (DON) was done. DON reported after the incident he interviewed CNA5 and during the interview CNA5 reportedly stated while changing R2's diaper "You have to be rough with him ...". DON reported CNA5 could not recall if she called R2 a derogatory term and slapped his thigh. Inquired with DON if staff members complained of CNA5's rough technique when providing care, DON stated it has been mentioned that CNA5 "

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4 115	Continued From page 4 ...would be a little rough repositioning or changing diapers ..." and he had verbal undocumented conversations with CNA5 about it. Inquired if CNA5's reported behavior on 09/22/21 was appropriate, DON stated it would be inappropriate to use profanities in front of a resident and/or at a resident. Review of the facility's employee conduct titled "APPENDIX I" dated April 2007 documents an employee must not use " ...abusive, profane, or obscene language, threatening, fighting or engaging in any act of physical aggression ...either by words or actions, directed at a residents, visitors, doctors, supervisor, member of the Facility ..." Review of the faculty's resident rights and responsibilities dated August 2007 documents under dignity "The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. "	4 115		
4 195	11-94.1-46(l) Pharmaceutical services (l) All drugs, including drugs that are stored in a refrigerator, shall be kept under lock and key, except when authorized personnel are in attendance. The facility shall be in compliance with all security requirements of federal and state laws as they relate to storerooms and pharmacies. This Statute is not met as evidenced by: Based on observation, review of the facility's policy and procedure, and interview with staff	4 195	Preliminary staff education was done on August 5, 2022, by the Director of Nursing	8/19/22

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4 195	Continued From page 5	4 195		

members the facility failed to ensure all medications used in the facility were securely stored in locked compartments. This deficient practice has the potential to affect all residents in the facility by increasing the risk of injury for any resident, or visitor who can access the medication cart.

Findings Include:

On 07/12/22 at 08:19 AM, while entering the facility, observed an unlocked and unattended medication cart. Inquired with Director of Nursing (DON) if the medication cart should be locked, DON immediately locked the cart and confirmed it should have been locked.

On 07/12/22 at 03:41 PM, as the Assistant Director of Nursing (ADON) approached this surveyor, observed an unlocked and unattended medication cart. Inquired with ADON if the medication cart should be unlocked and unattended, ADON stated it should have been locked.

On 07/15/22 at 09:52 AM observed an unlocked and unattended medication cart outside of resident rooms. Observed Registered Nurse (RN) 3 approach the medication cart and RN3 confirmed she was assigned to the medication cart. Inquired if the medication cart should be unlocked and unattended, RN3 stated she had to get a disinfecting spray and confirmed it should have been locked.

Review of the facility's policy and procedure "MEDICATION STORAGE IN THE FACILITY" revised on January 2018 documents "Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications are

to discuss locking of the medication carts when not attended. An audit sheet was created on July 20, 2022, to monitor all six medication carts daily x 2 weeks for every shift, then 3 days a week x 2 weeks for every shift, then 1 day a week x 1 week. After this period, carts will be randomly audited for compliance.

Further in-servicing will be done by the Director of Nursing on August 19, 2022 with the nursing staff.

Cart 6 is moved in front of the Medication Room when the cart is shared among multiple nursing staff. The shared cart key is kept in the Medication Room and returned when not in use.

Audits will be done by the Director of Nursing, Assistant Director of Nursing or designee. Results will be reported at the quarterly QA/QI Committee meetings.

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4 195	Continued From page 6 permitted to access medications. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access.	4 195		