| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| HI'OLANI CARE CENTER AT KAHALA NUI | 4389 MALIA STREET HONOLULU, HI 96821 |

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| F 000 | INITIAL COMMENTS<br><br>A recertification survey was conducted by the State Agency (SA), Office of Health Care Assurance (OHCA) on 09/20/22 to 09/23/22. The facility was found to be not in substantial compliance with 42 CFR 483 Subpart B.<br><br>Survey Census: 16 Residents<br><br>Sample Size: 8 Residents | F 000 | | |
| F 656 SS=F | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its | F 656 | | 10/3/22 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/04/2022

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| F 656 | Continued From page 1<br>rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to ensure comprehensive person-centered care plans were developed and/or implemented for one (1) resident, (Resident (R)2), of eight (8) residents sampled. As a result of this deficiency, resident is at risk to not achieve their highest quality of life. This has the potential to affect all residents in the facility.<br><br>Findings include:<br><br>On 09/20/22 at 10:18 AM, conducted an observation of R2 in the resident's room seated in a wheelchair with a towel roll in the resident's left hand (appeared to have contracture), a large towel under her left arm (near the underarm), and holding the call light cord between her thumb and pointer finger with her right hand. There were two (2) pages posted on R2's closet which provided written instructions and pictures of the set-up staff should implement to prevent worsening of | F 656 | The interdisciplinary team under the direction of the Director of Nursing, Assistant Director of Nursing and MDS Coordinator RN in consultation with the attending physician reviewed and updated the resident's care plan to address pain management and to develop a plan that included both pharmacological and non-pharmacological interventions. The Director of Nursing, Assistant Director of Nursing and MDS Coordinator RN will ensure that each resident's care plan is fully developed within seven days after completion of the comprehensive assessment, updated and that documentation is maintained in an up-to-date manner and reflective of the care required to maintain and support the residnet's quality of life. This will include a comprehensive pain managment plan that includess non-pharmacological interventions for the managment of pain. | |

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| F 656 | Continued From page 2<br>contractures and to protect the resident's skin related to contractures. The pictures depicted R2 with a palm protector applied to her left hand, a towel placed under her left arm (underarm area), and a large, rolled towel resting on her lap, positioned between her arms (separating her arms, preventing the resident's arms from folding in and closing due to contractures). At 11:14 AM, observed R2 in the room near the nursing station (primarily used for activities) with a towel roll in her left hand and under her left arm. Multiple observations (on 09/20/22 at 1:15 PM; 09/21/22 at 09:17 AM, 11:45 AM, and 01:12 PM; and 09/22/22 at 09:20 AM) were made of R2 without a palm protector applied to her left hand and no towel placed between both arms to prevent the worsening of contractures and to protect the resident's skin integrity.<br><br>On 09/22/22 at 09:35 AM, conducted an interview, concurrent record review of R2's hard chart (located on the unit), and observation of R2 with the Director of Nursing (DON). Reviewed R2's comprehensive person-centered Care Plan documented under the ADL (Activities of Daily Living) Functional/Rehab potential an intervention to "Apply left hand splint and provide ROM/skin care prior to applying left anti-spasticity splint 2x/day (two times per day) (9 am -12 and 3 pm-6 pm), check for skin breakdown/redness after remove splint" was started on 09/14/22.<br><br>-Review of the Therapist Progress & Discharge Summary- OT-2/2/2022 documented an analysis of functional outcome/ clinical impression: Care giver training provided to CNA in modifying was to apply left thumb protector to prevent base of thumb to rub against the edge of thumb opening and causing skin tear of left thumb. Therapist | F 656 | All care plans were reviewed to ensure that pain managment has been addressed and documented appropriatly. Going forward, the IDT team will ensure that pain managment will be addressed thru consultation with the attending physician, resident and staff. A twice weekly meeting is held with the interdisciplinary team to review each residnets status, monitor their condition, any changes of status to ensure the care plan remians uptodate. Any corrections or modifications, including a review of interventions for pain management or other issues are addressed and that interventions are monitored and any solution, plan of action or order from the physician are carried out and sustained as needed.<br>The Director of Nursing, Assistant Director of Nursing and MDS Coordinator RN are responsible for this action. | |

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| F 656 | Continued From page 3<br>also used the rolled bath towel to keep both hands in separate position not crossing over to maintain elbow neutral position, which were both depicted in the picture of R2's closet.<br><br>- After reviewing R2's chart, conducted an observation of R2 and concurrent interview with the Director of Nursing (DON). Observed R2 in the room. R2 was seated in a wheelchair, without a towel roll between her arms, and the palm protector was not applied to the resident's left hand. DON confirmed according to the comprehensive care plan, R2 should have had a palm protector applied to her left hand and a large towel roll placed between R2's arms but was not. DON stated a towel roll was placed in R2's left hand in lieu of the palm protector. Inquired with the DON and requested for the DON to product R2's palm protector. DON could not locate the palm protector. DON inquired with Certified Nurse Aide (CNA)1 regarding the location of the palm protector. CNA1 could not find R2's palm protector and was unaware of how long R2's left-handed palm protector was unavailable. CNA1 and DON reported FM2 will take the palm protector home to wash it and will bring it back and the palm protector is probably with FM2. DON and CNA1 both confirmed the facility does not know when FM2 took home the palm protector and currently does not have a process implemented to track when R2 is without the palm protector. The DON also confirmed alternative interventions were not developed for staff to implement when FM2 takes the palm protector home to wash to ensure R2 receives consistent care according to professional standards of care. | F 656 | | |
| F 657 SS=D | Care Plan Timing and Revision | F 657 | | 10/3/22 |

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| F 657 | Continued From page 4<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews, and record review, the facility failed to revise a comprehensive care plan after each assessment for one (1) resident, (Resident (R)12), of eight (8) residents sampled. As result of this deficiency, a resident's pain was not managed according to professional standards of practice and has the potential for harm. | F 657 | This residents care plan was reviewed and updated to include the fact that the family takes the palm protector home to periodically wash it. Additionally, Hi'olani ordered several new palm protectors for the residents use. This will ensure that the resident always has a palm protector available, even when one is out for | |

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| F 657 | Continued From page 5<br><br>Findings include:<br><br>On 09/20/22 at 11:56 AM, conducted an observation of Occupational Therapy staff (OTS) transferring R12 to a shower chair next to the resident's bed. OTS explained he/she was conducting a trail to see if R12 could tolerate sitting in a shower chair for the time needed to complete a shower. OTS stated R12 has chronic pain and has been receiving bed baths since admission due to R12's inability to tolerate the pain while sitting in the shower chair.<br><br>On 09/21/22 at 09:04 AM, conducted an interview with R12. During the interview, R12 reported having unrelieved pain and when she reports having pain, she is given medication. Inquired if staff implement non-pharmacological interventions to relieve the pain. R12 stated only medications and denied non-pharmacological interventions (repositioning, distraction, hot/cold therapy etc.) were implemented.<br><br>On 09/22/22 at 12:28 PM, conducted a review of R12's electronic medical record (EMR) and hard chart. R12 was admitted to the facility on 11/17/21 with diagnosis that include hemiplegia following a cerebral infarction, contusion of the scalp, multiple fractured ribs, and dorsalgia (chronic pain).<br><br>-Review of R12's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/24/21 documented in Section C. Cognition, an interview was not conducted (resident is rarely/never understood). Section I. Active Diagnosis, Muscuskeletal, I4000. was marked for fractures. Section J. Health | F 657 | cleaning. A rolled towel will also be used to be placed between the resident arms as needed. The resident's care plan and appropriate interventions were reviewed by the Interdisciplinary team, Director of Nursing, Assistant Director of Nursing, Staff nurses and CNAs to ensure that the resident's palm protector, rolled towels are always in place at the appropriate time. This included a retraining inservice with the CNAs and charge nurses. Additionally, the use of the plam protector (intervention, functional outcome and clinical impression) was reviewed with therapy to ensure that its use was still approprate, that it was being taken off at intervals (as needed), and that the family was made aware of the additional plam protectors ordered.<br>A review was completed of all resident care plans to ensure that any therapy device interventions are documented and interventions monitored. The interdisciplinary team under the director of the Director of Nursing, MDS Coordinator RN, therapy staff and attending physician will care plan the use of any future therapy interventions such as the use of palm protectors or other devices. | |

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| F 657 | Continued From page 6 | F 657 | | |

Conditions for pain management R12 had received pain medication and did not receive non-medication intervention for pain. Section N. Medications documented R12 was administered an opioid once within the look back period. Section V. documented pain was not triggered as a care area despite the resident's diagnosis of fractures. Quarterly MDS with ARDs of 05/25/22 and 08/24/22 both documented Section J. Health Conditions for pain management R12 had received pain medication and did not receive non-medication intervention for pain. Section N. Medications documented R12 received opioid medication for all 7 days of the look back period.

-Review of R12's Physician Orders documented an order for Acetaminophen 650 mg by mouth 1 hour before therapy give with Tramadol; every 4 hours as needed for mild pain, pain level 1-3/10 maximum 4 grams Tylenol per 24 hours for pain (started 11/19/21) and Tramadol HCL 50 mg by mouth every 6 hours as needed for moderate (pain level 4-6/10) to severe pain (pain level 7-10/10) for pain (started 11/17/21).

-Review of R12's Medication Administration Record (MAR) from November 2021 to current documented, R12 was administered Acetaminophen 650 mg and Tramadol 50 mg almost daily for pain.

-R12's progress notes documented a fax form submitted to R12's physician on 08/20/22 informing him/her that R12 has been receiving Tramadol 50 mg every evening around 8:00 PM for pain to her back and left arm/shoulder contracture pain, consistently rates pain 5/10, sometimes 6-7/10 for breakthrough pain, reports Tramadol is effective each dose, sometimes

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| F 657 | Continued From page 7 | F 657 | | |

request Acetaminophen 650 mg with the Tramadol as it is more helpful to relieve pain and helps the resident to sleep, and requested that the Tramadol order to be changed from as needed (PRN) to scheduled. Indicating staff is aware that R12's pain is chronic, requires daily medication intervention for relief, and has the potential to and/or has affected R12's ability to sleep.

-Review of R12's most recent Interdisciplinary Care Plan (IDT) meeting (review date 8/31/22; conference date 09/01/22) documented R12's pain relief was not discussed during "Information on treatments and medications provided", despite staff informing R12's physician about the resident's on-going use of one or more medications for pain control on 08/20/22.

-Review of R12's Comprehensive Care Plan (CCP) documented pain was only addressed in the ADL (activity of daily living) Functional/Rehab Potential as an intervention to monitor for pain level daily during care and as needed. Follow PRN pain regime and monitor for effectiveness and potential adverse reaction such as (Tylenol) liver toxicity, GI upset/bleed; (Tramadol) drowsiness, lethargy, constipation, nausea, vomiting, pruritus when administered." Non-pharmacological interventions, monitoring for unrelieved pain, pre-medicating resident before activities, and/or identification of pain's affect on R12's ADLs were not included in R12's CPP.

On 09/22/22 at 1:25 PM, conducted an interview with the DON regarding R12's pain. The DON confirmed a CCP for pain should have been developed and include non-pharmacological

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| F 657 | Continued From page 8<br>interventions for management of R12's chronic pain but was not.<br><br>On 09/22/22 at 1:33 PM, conducted a concurrent record review of R12's medical record (electronic and hard chart) and interview MDS staff (MDSS)1 regarding R12's pain. MDSS1 confirmed pain was not triggered during R12's admission MDS. However, R12's diagnosis of fracture and documented dorsalgia, continued use of medication for pain management (documented on R12's quarterly MDS (05/24/22 and 08/24/22), and staff's identification of R12's consistent use of pain medication, recommendation to the physician should have came up in the IDT team meeting, and the CCP should have been revised for pain management but was not.<br><br>On 09/22/22 at approximately 2:40 PM, the facility provided a printed copy of R12's CCP as requested by this surveyor. Review of the CCP provided documented the facility revised the care area (category) to include pain management with pharmacological and non-pharmacological interventions. | F 657 | | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent | F 812 | | 10/4/22 |

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| F 812 | Continued From page 9<br>facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interview, the facility failed to properly store and discard expired food from the walk-in refrigerator. As a result of this deficiency, the facility put all the residents at risk for foodborne illness.<br><br>Findings include:<br><br>During a walk-through tour of the kitchen on 09/20/22 at 09:00 AM, the following foods had "Use by" dates that have already past which indicated that the foods were expired and should have been discarded. 1. One container of Cole Slaw with Use By date of 09/08/22 at 12:00 PM, 2. One container of Carrots with a Use By date of 09/12/22 at 10:29 AM, 3. One container of Red Peppers with Use By date of 09/17/22 at 08:05 PM.<br><br>During an interview on 09/20/22 at 09:15 AM, the Director of Dining Services (Dir of Dining) acknowledged that the foods previously mentioned were expired and should have been discarded. Dir of Dining further stated that they would look at all the other foods and discard if indicated. | F 812 | The director of Dining took immediate action to remove and discard the expired items. Additionally, a compete review was done of other existing foods to ensure that there were no other foods that had pasted the expiration dates. The Director of Dining reviewed this issue with the kitchen staff including how to find expiration date on the many different packaging items for food received and stored in the refrigerators, store rooms or freezers. Additionally, this will be discussed during kitchen staff meetings. The Director of Dining, Dietitian, Dining Supervisors will periodically check (spot check) to ensure that food items (including raw food, stored prepared food or other items are used by the "use date" or if not, removed from the inventors. This process also includes spot checking food temperatures in addition to watching for use by or expiration dates. Corrective actions regarding staff performance to food storage, disposal of expired items (if any) will be reviewed the monthly QAPI/CQI meeting.<br>The Director of Dining, Dietary Supervisor and Dietitian are responsible for this action. | |

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