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
	125055	A. BUILDING: ______ B. WING ______	09/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HI'OLANI CARE CENTER AT KAHALA NUI	**4389 MALIA STREET HONOLULU, HI 96821**

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4 000	Initial Comments A relicensure survey was conducted by the Stat Ageny (SA), Office of Healthcare Assurance (OHCA) on 09/20/22 to 09/23/22. The facility was not in substantial compliance with Hawaii Administrative Rules, Title 11, Chapter 94.1. Survey Census: 16 Residents Sample Size: 8 Residents	4 000		
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 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. Findings include: 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	4 159	The Director of Dining took immediate action to remove and discard the expired items. Additionally, a complete review was done of other existing food items to ensure that there were no other items that we past the use by or expiration date. The Director of Dining reviewed/discussed this issue with the kitchen staff including how to find the expiration or use by date on the many different packaging/containers of food received and stored in the refrigerators or freezers. This issue was	10/4/22

Office of Health Care Assurance

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/04/22

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4 159	Continued From page 1 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. 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.	4 159	also discussed during kitchen staff meetings. The Director of Dining, Dietitian, Dining Supervisor will periodically check (spot check) to ensure that food items (including raw food products, stored prepared food or other perishable are used by or before the appropriate expiration date. This process also includes spot checking food temperatures in addition to the use by or expiration date. Corrective action regarding performance of food storage, disposal of expired items or related dining issues will be discussed at the monthly QAPI meeting. The Director of Dining, Dietary Supervisor and Dietitian are responsible for this action.	
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. This Statute is not met as evidenced by: 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. Findings include:	4 175	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 residents care plan to address pain management and to develop a plan that included pharmacological and non-pharmacological interventions. The Director of Nursing, Assistant Director of Nursing and MDS Coordinator RN will	10/3/22

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4 175	Continued From page 2 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. 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. 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). -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 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	4 175	ensure that each resident 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 reflective of the current care requirements for each resident to ensure their quality of life (and that their pain, if any, is managed in an appropriate and timely manner). All care plans were reviewed post survey to ensure that pain management has been addressed and documented appropriately and in a timely manner. Going forward, the interdisciplinary team will ensure that pain managment is addressed thru consultation with the attending physician, resident and staff. A twice weekly meeting is held with the interdisciplinary team to review each reidents status, monitor their condition, any changes of status and to ensure the care plans remain uptodate. Any corrections or modifications, including a review of interventions for pain management or other issues are addressed in a timly manner and that interventions are monitored and any solution, plan of action or order from a physician are carried out and sustained as needed.The Director of Nursing, Assistant Director of Nursing and MDS Coordinator RN are responsible for this action.	

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4 175	Continued From page 3	4 175		

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 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

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4 175	Continued From page 4	4 175		

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 interventions for management of R12's chronic pain but was not.

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

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4 175	Continued From page 5 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. 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.	4 175		