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 _____	08/10/2023

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

(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) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on August 10, 2023. The facility was found not to be in substantial compliance with the requirements of §42 CFR 483, Subpart B for Long Term Facilities. Survey dates: August 7, 2023, to August 10, 2023. Census: 16 residents Sample Size: 16	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.	F 583		9/4/23

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

Electronically Signed | 09/20/2023

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 583	Continued From page 1 §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and interview with staff members the facility failed to ensure R263's personal medical information was secured for confidentiality. Findings include: On 08/08/23 at 09:01 AM observed Registered Nurse (RN)5 enter R263's room and stated she was going to give R263 his insulin. Outside of R5's room, in the hallway shared by staff, residents, and visitors, the insulin cap that included R263's name and medication he was taking was left on the Personal Protective Equipment (PPE) cart unattended and easily assessable for anyone to pick up and read the information. On 08/10/23 at 09:16 AM interview with Director of Nursing (DON) was done. Inquired if it was standard of practice and acceptable to leave an empty medication bottle with resident's information on it out in the open unattended, DON stated no.	F 583	Medication pass observation was completed by the Nurse Educator on insulin administration including observing properly securing Personal Health Information (PHI) and HIPAA on 8/8/2023. Further more, in-service training was done by the Nurse Educator with licensed nurses and CNAs on PHI/HIPAA compliance on a number of dates (August 22, 23, 24, 25, 27, 30 and September 4th) to ensure all staff member received the training. Random observations re; PHI/HIPAA compliance audits continue to be done by the Nurse Educator and the Assistant Director of Nursing.	

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 583	Continued From page 2 Review of the facility's policy and procedure number DR-140 effective 06/15/12 "Protected Health Information & HIPA" documented "This policy and procedure outlines the responsibility of Associates and other...[facility]...stakeholders to protect and safeguard individuals protected health information (PHI) that is maintained or transmitted in any form or medium." The policy and procedure defined PHI "...as identifiable health information, whether oral or record in any form or medium, including electronic, that related to the individual's past, present, or future physical or mental health or condition..." Under the facility's responsibility the policy and procedure documented "We are required by law to maintain the privacy and security of your protected health information."	F 583		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		9/4/23

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 584	Continued From page 3 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interiew with staff members,the facility failed to provide a homelike environment for two residents in the sample. Findings include: 1) On 08/08/23 at 09:10 AM, observation in Resident (R)4's room found areas of scraped off paint on the wall behind the resident's headboard. On 08/09/23 interview and concurrent observation was done with housekeeping staff. The staff confirmed the scraped paint on the wall and reported a work order was submitted approximately a week ago; however, staff was not sure if a work order was sent to maintenance.	F 584	Room 594B & Room 492 with needed wall repair was fixed by Maintenance on 8/9/23. Additionally, staff received in-service training regarding the importance of keeping the environment safe, clean, comfortable and well maintained . The training included how to generate work orders or to alert Housekeeping when items need repair, painting or cleaning.This training was completed by the Nurse Educator for the licensed nurses and the CNAs on August 22,23,24, 25, 27 , 30 and September 4th . The Ward Clerk/ designee will conduct weekly rounds in resident rooms and common areas and generate work orders	

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 584	Continued From page 4 2) On 08/08/23 at 08:45 AM observation in R263's room found two areas of scraped off paint behind the wall of R263's headboard. On 08/09/23 11:45 AM interview and concurrent observation was done with Registered Nurse (RN)5 in R263's room. RN5 confirmed the scraped paint on the wall and stated she does not know if it was reported, or a work order was submitted to maintenance. RN5 reported maintenance usually handles things within two to three hours for immediate work orders and within 24 hours for something non-immediate, such as scraped paint on the wall. On 08/09/23 at 04:15 PM a telephone interview was conducted with the Maintenance Supervisor (MS). Inquired whether he received work orders for room 594B and 492A. MS responded he received a work order for room 594 for a clogged toilet and room 492 for the wall behind the bed board. MS clarified he received the work order for room 492 today (08/09/23) at 12:30 PM, when the housekeeping staff reported the scraped wall to him. MS confirmed he did not have a work order for the wall behind R4's headboard. MS reported anyone can generate a work order.	F 584	accordingly as well.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		9/4/23

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 684	Continued From page 5 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff member, the facility did not assure a resident's bowel protocol was implemented, which placed the resident at risk for constipation or bowel impaction related to use of an opioid (pain reliever with common side effect of constipation) for one of one resident in the sample. Findings include: Resident (R)1 was admitted to the facility on 10/26/22. Diagnoses include but not limited to hypertensive heart disease with heart failure; encounter for palliative care; chronic diastolic (congestive) heart failure; and major depressive disorder. Record review noted physician orders for fentanyl patch (opioid) 24 mcg one patch transdermal every three days. Physician also ordered the following bowel protocol docusate sodium tab, 86 mg/50mg by mouth once daily for constipation (hold for loose stools); MiraLAX, give 17 gram/dose once daily for constipation; milk of magnesia (MOM), 30 ml by mouth daily as needed, x2 days no BM; and Dulcolax, 10 mg. rectally x3 days, no result from MOM (hold for loose stools). On 08/10/23 at 10:52 AM concurrent record review and interview was done with Charge Nurse (CN)5 at the nurses' station. CN5 confirmed resident receives fentanyl. Reviewed R1's bowel movement record and medication administration record (MAR). Review for the	F 684	In-service training conducted by the Nurse Educator for the licensed nurses and CNAs regarding the importance of documenting bowel movement and providing appropriate bowel regimen to residents. Licensed nurses will check CNA compliance charting in the point of care system during their shift to ensure that documentation is completed appropriately and completely on each shift and offer bowel regimen as appropriate. Random audits will be done by the Assistant Director of Nursing on Point of Care compliance. Training was conducted on August 22, 23, 24, 25, 27, 30 and September 4th by Nurse educator to Licensed Nurses and CNAs to ensure all staff had the opportunity to participate.	

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 684	Continued From page 6 month of August 2023 found R1 did not have bowel movement for three days (08/01 to 08/03/23). CN5 reviewed the MAR and confirmed MOM and/or Dulcolax suppository was not offered or administered as ordered by the physician. CN5 confirmed if the medications were offered and refused, this information would be documented in the MAR. There was no documentation R1 refused medications. A review for the month of July 2023 noted R1 did not have bowel movement for three days (07/25 to 07/27/23) followed by large bowel movement on 07/28/23. Review of the MAR found MOM and/or suppository was not administered on day two or day three as prescribed. Also noted there was no documentation to note whether R1 had a bowel movement on the following shifts: day shift (07/09, 07/16, 07/17, 07/23, 07/29, and 07/30/23), evening shift (07/29/23), and NOC shift (07/01, 07/02, 07/15, an 07/19). CN5 confirmed the importance of documenting whether R1 had a bowel movement to ensure accuracy and the need to implement the physician prescribed bowel protocol.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and	F 688		9/4/23

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 688	Continued From page 7 services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a resident with limited range of mobility received treatment to prevent decrease in range of motion/mobility for one of one Resident (R)4 in the sample for limited range of motion. Findings include: Resident (R)4 was admitted to the facility on 11/17/21 from an acute hospital. Admission diagnoses included acute stroke with left sided weakness, slurred speech, expressive aphasia, mild dysphagia, and multiple fracture to left rib. On 08/08/23 at 12:27 PM observed R4 lying in bed, her left arm was bent at the elbow and the left hand was fisted and turned toward the wrist. There was a rolled-up towel in her left hand and a large towel roll in the left crook of her arm (by the elbow). R4 reported that the Certified Nurse Aides (CNA) are afraid to do range of motion because they don't want to cause her pain. The therapist will perform the range of motion. Review of the quarterly Minimum Data Set (MDS) with an assessment reference date of 05/24/23, R4 was coded with functional limitation in range of motion for the upper and lower extremities on	F 688	Staff training and education was done by the Nurse Educator on how and when to do Passive Range of Motion to resident 4 on August 22, 23, 24, 25, 27, 30 and September 4th to ensure all staff were able to participate in the program. The training included a refresher on how to add to the Electronic Treatment Administration Record and how to perform passive range of motion/stretching on resident 4's left elbow, left wrist and fingers on the left hand prior and after removing the splint. This will be verified by the licensed nurse on shift and documented appropriately. Range of motion/stretching training was covered as a general subject for all residents in addition to the focus on resident 4. Additionally, in service training done on August 22, 23, 24, 25, 27, 30 and September 4th also covered ROM for all other residents. This included hands on training for Nurses on how to do passive Range of motion /stretching prior to application and after removal of splints and the like or other passive range of motion /stretching as per Physician order. Such passive range of motion/stretching will be included in the electronic treatment	

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 688	Continued From page 8 one side. A review found a care plan for activities of daily living to follow therapy recommendations when available. Review of rehab note dated, 07/25/23 documented, alternative elbow splint when posey elbow splint not available/working, apply as tolerated at all times except for meals, bed bath, and removed as requested. Further noted intervention to provide range of motion prior to applying and after removing splints, check skin integrity (redness, swelling, skin breakdown, or pain) before application and after removal of splints. On 08/09/23 at 09:11 AM, interviewed CNA8. CNA8 reported she will perform range of motion when the splint is removed and prior to applying the splint. CNA8 reported the splint is removed during mealtimes. Inquired where do they document that range of motion was performed. CNA replied they do not document when they do range of motion. CNA further explained that physical therapy does range of motion two to three times a week. Further questioned what she does upon removal and application of splint. CNA8 stated she will massage the arm and try to stretch the arm out straight. CNA8 also stated R4 will sometimes request to remove the splint. On 08/09/23 at 11:15 AM, observed a posting next to the resident's bed for splint treatment plan, effective 07/25/23. Instructions include: Keep both splints on at all times except meals, shower, and as requested for temporary removal by resident: provide range of motion prior to applying and after removing splints; check skin integrity before application and after removal of splints (please notify licensed nurse of redness, swelling, skin breakdown, or pain); apply elbow splint first followed by resting hand splint; and	F 688	administration record for Licensed Nurses and it will be checked/audited that it was performed per the orders. Random checks and observation will be done by Nurse educator and Assistant Director of Nursing. The Nurse Educator will also conduct periodic review of the techniques being used by the staff when assisting residents for require range of motion and or streatching assistance.	

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 688	Continued From page 9 straps, hand washing in warm water and mild soap, dry at room temperature, be sure the splint is completely dry before reapplying, if splint has a cover you can remove and wash cover separately. Date updated was 07/25/23. On 08/09/23 at 04:05 PM, interview and concurrent record review was conducted with the Assistant Director of Nursing (ADON) at the nurses' station. ADON confirmed there is no physician order for performing range of motion and there is no documentation in the electronic health record that range of motion is being performed after removal and before applying the splint.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide one resident (R)5 of one resident in the sample, adequate supervision and assistance to prevent falls. R5 was not receiving adequate hydration (cross reference (cr) to F692 Nutrition and hydration) and timely assistance to use the bathroom (cr to F690 bladder and bowel incontinence). The deficient practice places the resident at risk for injury.	F 689	Staff in-service training was completed by the Nurse Educator for the licensed nurses and CNAs. The focus was on conducting purposeful rounding on resident 5 and to offer toileting every 2 hours (or more often as needed) while awake. The training included a review of the four "Ps" (position, pain, potty, possession - frequently used items in reach), as items to check during	9/4/23

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 689	Continued From page 10 Findings include: Observed R5 on 08/08/23 at 09:57 AM lying in bed with her eyes closed. Noted bed in low position, fall mat on the floor on her right side. When asked if R5 is alert and oriented or whether she gets out of bed, the Housekeeper (H)1 said she usually doesn't say anything or talk much. Sometimes she gets up to go to activities. During a telephone conversation with R5's family member (FM)1 on 08/08/23 at 2:05 PM. FM1 stated, I don't think she (R5) uses the bedside commode, and I don't think the staff are getting her up to go to the bathroom as often as they should be. She fell last week because she got up in the middle of the night to go to the bathroom. She's okay, the staff called me to tell me that she fell and has no injuries. They do take a long time to respond to my mom's call light when she needs help. Surveyor asked how many falls has she had in the last year? FM replied that R5 has fallen around four times. She didn't have any noticeable injuries, but she did have a lot of pain and soreness. Most of the time it's because she frequently needs to go to the bathroom. I've hired a private certified nurse aide (CNA) to come in during the evening because she is not drinking enough fluids, or getting out of bed. They come in before dinner and stay until she goes to sleep. The CNA comes in and assists her at dinner, and does her evening bath. Electronic medical record (EMR) reviewed on 08/08/23 at 3:35 PM. Care plan reviewed. Problem: Potential for falls. R5 has impaired balance and unsteady gait which	F 689	purposeful rounding. All falls will continue to be reviewed and discussed during shift to shift reporting, bi-weekly stand-up meetings, and at the monthly Falls QAPI/CQI sub-committee meeting. Staff training was conducted on August 22, 23, 24, 25, 27 and 30 and September 4th to ensure all licensed staff and CNAs had the opportunity to attend. The Assistant Director of Nursing will monitor and spot check compliance. In addition to the focus on resolving the issue with resident 5, this training, oversight and focus on toileting is applicable to all residents.	

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 689	Continued From page 11	F 689		

put her at risk for fall and injuries. Other risk factors for fall include weakness and fatigue, Parkinson's disease, poor safety awareness, impaired cognition and communication due to Dementia, use antidepressant, etc. She has history of falls prior to nursing admission. Found resident sitting on floor with back supported by the bed without visible injuries on 8/29/22, added safety fall mat to right side of bed . On 9/8/22 at 0135, found resident was kneeling with right knee on safety fall mat and holding enabler with both hands, no visible injuries noted. On 10/16/22, found on floor (FOF) with skin tear to right lateral eyebrow. FOF on 11/13/22 at opened bathroom door without visible injuries. FOF on 2/11/23 with sitting position without visible injuries, found resident sitting on floor right side of bed without injuries noted on 4/21/23. On 7/30/23, found resident lying on the floor without visible injuries. Noted R5 had seven falls within the last year.

Requested a list of falls and dates for R5 for past one year from the Director of Nursing (DON) on 08/09/23 at 03:13 PM. Asked if there were any incident reports for R5, the DON said there were two. Whenever there is a fall we round with the quality assurance performance improvement team to discuss the fall and do a root cause analysis. We also track and discuss any falls during our QAPI meeting every month.

Falls management system policy dated November 12, 2019, reviewed on 08/10/23 at 12:55 PM. Purpose B. 7. The goal of this program is to prevent or to minimize fall risk that might result in serious injury ...II. Policy A. It is the policy ...to provide each facility Resident ...appropriate interventions to minimize the

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 689	Continued From page 12 possibility of falls occurring. IV. Procedure A. Resident Assessment: 3. A "Falls Risk Assessment" score of 10 or above represents a high risk for falls ...VIII. Risk factors associated with falls. A. 9. Bladder or bowel incontinence. 21. Fluid imbalance. C. Care Giver Factors: 2. Toileting schedule not maintained. 6. Rounds not made as required.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 690		9/4/23

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 690	Continued From page 13 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide one resident (R)5 of one resident in the sample, adequate supervision, and assistance to prevent falls. R5 was not receiving adequate hydration (cross reference (cr) to F692 Nutrition and hydration) and timely assistance to use the bathroom (cr to F690 bladder and bowel incontinence). The deficient practice places the resident at risk for injury. Findings include: Observed R5 on 08/08/23 at 09:57 AM lying in bed with her eyes closed. Noted bed in low position, fall mat on the floor on her right side. When asked if R5 is alert and oriented or whether she gets out of bed, the Housekeeper (H)1 said she usually doesn't say anything or talk much. Sometimes she gets up to go to activities. During a telephone conversation with R5's family member (FM)1 on 08/08/23 at 2:05 PM. FM1 stated, I don't think she (R5) uses the bedside commode, and I don't think the staff are getting her up to go to the bathroom as often as they should be. She fell last week because she got up in the middle of the night to go to the bathroom. She's okay, the staff called me to tell me that she fell and has no injuries. They do take a long time	F 690	Staff in-service training was completed by the Nurse Educator for the licensed nurses and CNAs. The focus was on conducting purposeful rounding on resident 5 & to offer toileting every 2 hours (or more often as needed) while awake. The training included a review of the four "Ps" (position, pain, potty, possession - frequently used items in reach), as items to check during purposeful rounding. All falls will continue to be reviewed and discussed during shift-to-shift reporting, bi-weekly stand-up meetings, and at the monthly Falls QAPI/CQI sub-committee meeting. Staff training was conducted on August 22, 23, 24, 25, 27 and 30 and September 4th to ensure all licensed staff and CNAs had the opportunity to attend. The Assistant Director of Nursing will monitor and spot check compliance. In addition to the focus on resolving the issue with resident 5, this training, oversight and focus on toileting is applicable to all residents.	

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 690	Continued From page 14	F 690		

to respond to my mom's call light when she needs help. Surveyor asked how many falls has she had in the last year? FM replied that R5 has fallen around four times. She didn't have any noticeable injuries, but she did have a lot of pain and soreness. Most of the time it's because she frequently needs to go to the bathroom. I've hired a private certified nurse aide (CNA) to come in during the evening because she is not drinking enough fluids or getting out of bed. They come in before dinner and stay until she goes to sleep. The CNA comes in and assists her at dinner and does her evening bath.

Electronic medical record (EMR) reviewed on 08/08/23 at 3:35 PM.
Care plan reviewed.
Problem: Potential for falls.
R5 has impaired balance and unsteady gait which put her at risk for fall and injuries. Other risk factors for fall include weakness and fatigue, Parkinson's disease, poor safety awareness, impaired cognition, and communication due to Dementia, use antidepressant, etc. She has history of falls prior to nursing admission.
Found resident sitting on floor with back supported by the bed without visible injuries on 8/29/22, added safety fall mat to right side of bed . On 9/8/22 at 0135, found resident was kneeling with right knee on safety fall mat and holding enabler with both hands, no visible injuries noted. On 10/16/22, found on floor (FOF) with skin tear to right lateral eyebrow. FOF on 11/13/22 at opened bathroom door without visible injuries. FOF on 2/11/23 with sitting position without visible injuries, found resident sitting on floor right side of bed without injuries noted on 4/21/23. On 7/30/23, found resident lying on the floor without visible injuries. Noted R5 had seven falls within

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 690	Continued From page 15 the last year. Requested a list of falls and dates for R5 for past one year from the Director of Nursing (DON) on 08/09/23 at 03:13 PM. Asked if there were any incident reports for R5, the DON said there were two. Whenever there is a fall, we round with the quality assurance performance improvement team to discuss the fall and do a root cause analysis. We also track and discuss any falls during our QAPI meeting every month. Falls management system policy dated November 12, 2019, reviewed on 08/10/23 at 12:55 PM. Purpose B. 7. The goal of this program is to prevent or to minimize fall risk that might result in serious injury ...II. Policy A. It is the policy ...to provide each facility Resident ...appropriate interventions to minimize the possibility of falls occurring. IV. Procedure A. Resident Assessment: 3. A "Falls Risk Assessment" score of 10 or above represents a high risk for falls ...VIII. Risk factors associated with falls. A. 9. Bladder or bowel incontinence. 21. Fluid imbalance. C. Care Giver Factors: 2. Toileting schedule not maintained. 6. Rounds not made as required.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 692		9/4/23

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 692	Continued From page 16 §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to assist one Resident, (R)5 of one resident in the sample with enough fluids to maintain adequate hydration. The deficient practice placed the resident at a greater risk for dehydration, urinary tract infections and potentially increased the risk for injury (cross reference (cr) to F689 Free of Accident hazards/prevention/devices). Findings include: Observed R5 on 08/08/23 at 09:57 AM lying in bed with her eyes closed. When asked if R5 is alert and oriented or whether she gets out of bed, the Housekeeper (H) 1said, she usually doesn't say anything or talk much. Sometimes she gets up to go to activities. Noted the bedside table was out of reach close to the room divider. Did not note any cups or pitchers on the bedside table. Telephone conversation with R5's family member (FM)1 on 08/08/23 at 2:05 PM. Asked FM1 if her	F 692	In-service training was conducted by the Nurse Educator for the licensed nursing staff and CNAs on August 22, 23, 24, 25, 27 and 30th. Training was also done on September 4th. The training included the importance of adequate and appropriate ways to offer hydration and the proper documentation of hydration status, to include fluid supplements, med pass fluids, etc.) Residents who are having poor fluid intake will be encouraged to drink. Their hydration status will be reviewed during shift change and referred to the Registered Dietitian or attending physician as necessary for additional assistance, attention or adjusted orders. The training included the importance of good hydration and the option of adding liquid supplements. Resident 5's fuid intake status was reviewed including action steps to incourage fluid intake, documenting in the electronic health record. Additionally, this traiing is applicable to all residents whose hydration	

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 692	Continued From page 17 mom has had any urinary tract infections (UTI's)? She stated that she had received a call today from the staff there at the facility that reported that her mom's urinalysis result came back, and it was negative. She further explained that her mom has concentrated and smelly urine, so they tested her for a UTI. I think it is because she isn't drinking enough fluids throughout the day. I asked the staff if I can review her intake report to see how much she is drinking, but I didn't receive anything. She can drink fluids if she is offered some help. I don't think they have enough staff to make sure she gets enough fluids to drink or is getting up to go to the bathroom. to assist with meals and getting her extra fluids. She fell last week because she got up in the middle of the night to go to the bathroom. She's okay, they called me to tell me that she fell and didn't have any injuries (cr to F689). During an observation of R5 on 08/08/23 at 3:30 PM, noted R5 in her bed sleeping. Noted the overbed table was out of the reach and had a coffee cup with a lid. During an interview and record review with charge nurse (CN)10 on 08/09/23 at 09:49 AM Asked if R5 has a urinary tract infection (UTI), she looked in the EMR and replied that R5's urinalysis (UA) results were negative. We're pushing fluids with her, and the staff have reported that she is not having any more odorous urine. When asked if her fluid intake is being recorded, LN5 stated that her fluids are being measured at meals only and added that the fluids are also being given during the day, but they are not being measured. CN10 looked in the EMR to see how much she	F 692	status is monitored daily. The charge nurses are responsible for ensuring that each resident hydration status is up to date and that the CNAs are also monitoing intake. The Assistant Director of Nursing will ensure compliance with hydration status by spot checking resident hydration intake and status,	

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 692	Continued From page 18	F 692		

drinks and stated that she drinks about one to two cups of fluids per meal. CN10 said they are making rounds, but she usually sleeps. They don't want to wake her up to offer her fluids if she's sleeping, she may not be awake enough to swallow them. When asked when did she last have a UTI? he looked in the record and said it was last May of 2023.

Reviewed electronic medical record (EMR). Care plan on 08/09/23 at 11:08 AM.
Problem: R5 uses pads and briefs due to incontinent of bladder and bowel. She requires extensive assist with toileting. She has cognitive and communication deficits, functional impairment due to her multiple medical conditions. She is offered adequate fluids. Risks: UTI, skin breakdown, restlessness due to discomfort, etc. Staff continue to provide timely incontinent care as she does not call for assistance. She has urinary frequency, but no foul odor nor burning sense while voiding. UTI on 12/5/22 and 3/5/23. (Start date 08/09/23 Goal date: 11/07/23).
Will be clean, dry, odor free and no signs and symptoms (s/sx) of UTI through next review date.
Interventions: Monitor fluid intake daily and encourage fluid intake daily. Incorporate with nutrition care plan for hydration needs (cr F690).

Reviewed facility policy & Procedures titled Hydration Program June 17, 2012. Policy: Residents will be provided fluids which meets daily requirements to avoid consequences of dehydration. Procedure: 2. Resident refusal of adequate fluid intake must be documented in the medical record. 3. Nutrition and hydration needs will be monitored. 4. Daily fluids will be provided at meals, refreshments, bedside water and when

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 692	Continued From page 19 medications are administered.	F 692		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of	F 732		8/14/23

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 732	Continued From page 20 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview with staff members, the facility did not assure the nurse staffing posting included the facility's census for both units. Findings include: On 08/09/23 at 02:57 PM observed the nurse staffing posting at the nurses' station on the fourth floor. The posting did not include the facility's census. Concurrent observation with Registered Nurse (RN)7 confirmed no documentation of facility's census. RN7 reported the aides will do the posting. On 08/09/23 at 03:08 PM, concurrent observation was done with the Director of Nursing (DON). DON confirmed the posting did not document the facility's census. The posting noted the following, "Daily posting of this information is required for nursing homes participating in Medicare/Medicaid." DON stated any of the staff members can complete this form, nurses, or the aides. 2) Observations of the daily nurse staffing posting on the fifth floor on 08/08/23, 08/09/23, and 08/10/23 found the daily census number not included on the postings. On 08/10/23 at 12:42 PM interview with Certified Nurse Aide (CNA)10 and Registered Nurse (RN)6 was done. CNA10 confirmed the daily nurse staffing posting did not include the daily census and stated the census was 30. At 12:44 PM, RN	F 732	The Director of Nursing revised the information sheet that is posted at the Nurses Station to include the daily census. The Nurse Educator in-serviced the licensed nurses and CNAs regarding the revision made to the posted form. The new form was posted starting on August 11,2023. The charge nurse is responsible for posting an updated form every shift. The Assistant Director of Nursing and Director of Nursing will spot check the posted information during rounding.	

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 732	Continued From page 21 RN6 approached this surveyor and confirmed the posting does not include the daily census and they usually do not put it on the posting. RN6 further noted the facility will need to add a spot on the form to include the census.	F 732		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented	F 758		8/15/23

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 758	Continued From page 22 in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff member, the facility failed to ensure one of five residents sampled were free from unnecessary psychotropic medication. Resident (R)265 was prescribed an as needed (PRN) antidepressant for agitation/insomnia without the diagnosed specific condition documented in the clinical record and the facility failed to appropriately monitor the effectiveness of the medication and the resident's sleep pattern. Findings include: R265 was admitted to the facility on 07/22/23 with diagnosis of Dementia associated with other underlying disease without behavioral disturbances. R265's diagnoses did not include insomnia. Review of R265's physician's orders included Trazadone 50 milligram (mg) tablet, give 12.5 mg	F 758	On August 15th, the monitoring for behavior/medication effectiveness of antidepressant used for agitation/insomnia for resident 265 was completed. Additionally, Physician clarified to add diagnosis of agitation and insomnia for resident 265 which is an appropriate use of this antidepressant. The MDS Nurses and Assistant Director of Nursing reviewed all residents on psychotropic medications to ensure that proper diagnosis supports the psychotropic drug indication and that appropriate behavior/medication effectiveness and side effects monitoring was in place and completed (done by August 21,2023). Staff in-service training was conducted by the Nurse Educator for all licensed nurses and CNAs re: ensuring appropriate diagnosis is included with all residents on psychotropic medications as well as	

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 758	Continued From page 23 PRN for 14 days for agitation and insomnia by mouth three times a day ordered on 07/28/23. Review of R265's care plan documented "Takes as needed (prn) Trazadone for agitation and insomnia. No behavioral issues noted, however required use to help with sleep ...Will be able to sleep at least 6 hours at night and remain free of drug related cognitive/behavioral impairment; hypotension ...Administer and monitor effectiveness/side effect of medication ...Monitor sleeping pattern and anxiety daily ..." On 08/09/23 at 03:54 PM concurrent record review and interview with Assistant Director of Nursing (ADON) was done. Inquired what is being monitored for R265 for the use of Trazadone, ADON stated agitation and insomnia. ADON reported the facility will monitor R265's ability to maintain and initiate sleep and the behavior log would be in the Treatment Administration Record (TAR). Concurrent review of R265's physician's order under behavioral monitoring, ADON confirmed R265's behavioral monitoring orders does not include monitoring for Insomnia, R265's sleep pattern and the effectiveness of the medication. Review of R265's Medication Administration Record (MAR) and TAR for July and August documented R265 was administered the antidepressant, Trazadone, on 07/28/23 at 07:08 PM and 07/29/23 at 08:00 PM. The TAR did not include any documentation of insomnia or agitation on those days. Review of R265's nursing notes on 07/28/23 and 07/29/23 do not document R265 having trouble sleeping and/or agitation on those days. Further	F 758	initiating and ensuring proper documentation of psychotropic medication behaviors (to trend effectiveness) and side effect monitoring. The Psychosocial QAPI/CQI Subcommittee, will continue to discuss psychosocial issues to include psychotropics for appropriateness as well as other non-pharmacological interventions to help targeted behaviors. The Psychosocial QAPI/CQI subcommittee will continue to monitor and discuss each residents individual situation and make recommendation/s to the attending physicians as appropriate. The Associate Medical Director sits on this committee and along with the Consulting Pharmacist and nursing leadership assist with the review of each residents who is receiving psychotropic medications to determine if the medication needs to be discontinued, continued, put on hold, etc.	

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 758	Continued From page 24 review of R265's nursing notes leading up to the order of Trazadone does not include any non-redirectable indication of agitation or difficulty sleeping.	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview with staff and record review the facility failed to assure a resident was free of significant medication errors. Findings include: On 08/09/23 at approximately 11:32 AM Registered Nurse (RN)5 checked resident (R) 263's blood glucose level and reported it at 170. RN5 administered 5 units of insulin from R263's Novolog Flex pen per sliding scale. On 08/09/23 at 01:01 PM medication error was found during R263'S record review of medication reconciliation. Surveyor noted physician's medication order for insulin matched the resident's Medication Administration Record (MAR) which read: Novolog Flex pen U-100 Insulin apart 100 unit/ml (3 mL) subcutaneous [Insulin apart U-100] Type M-Medication - Administer SQ every before meals per sliding scale (may replace to Novolin R until Novolog supply available). Call MD if BG less than 70 or more than 400. No cover-BG less than 151. 3 units - BG 151-200. 5 units-BG 201-250. 7 units-BG 251-300. 9 units- BG 301-350. 11 units- BG	F 760	On 8/9/2023 R263s attending physician, the associate medical director, the resident's wife and the consulting pharmacist was notified of medication errors. No adverse reaction was noted with the resident on any of the medication errors. On 8/9/2023, Medication observation, training and critique was done by the Nurse Educator for RN6 on the proper administration of insulin. RN6 performed medication pass on Insulin administration and other medication pass properly following the 5 Rs (right resident, right dose, right medication, right time, right route of administration). The Nurse Educator provided in-service training to all licensed nurses regarding proper insulin administration and proper medication pass procedures for all residents. Also covered in this training were procedures to avoid medication errors and steps to take in the event there is a medication error. Training was conducted by the Nurse educator on 8/9/23, 8/22/23, 8/23/23,8/24/23,8/25,23,8/27/23,8/30/23 &	8/22/23

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 760	Continued From page 25 351-400. For DM II. R263 was given 5 units of insulin instead of the ordered 3 units, receiving 2 units of insulin more than what was ordered. Surveyor reported medication error to RN5, RN6, Assistant Director of Nursing (ADON) and Director of Nursing (DON). Surveyor reviewed the printed copy of R263'S MAR with RN5 who confirmed the medication error. Upon further review of R263'S MAR it was found there were five other medication errors for R263 in administration of insulin on 07/07/23, 07/08/23 and 07/09/23. 07/07/23 at 08:00 AM with blood sugar documented at 268 and given 9 units of insulin instead of the ordered 7 units. 07/07/23 at 12:00 PM with blood sugar documented at 279 and given 9 units of insulin instead of the ordered 7 units 07/08/23 at 08:00 AM with blood sugar documented at 288 and given 9 units of insulin instead of the ordered 7 units 07/08/23 at 12:00 PM with blood sugar documented at 276 and given 9 units of insulin instead of the ordered 7 units and on 07/09/23 at 08:00 AM with blood sugar documented at 164 and given 5 units of insulin instead of the 3 units of insulin ordered. RN5 confirmed the medication errors. Surveyor questioned if this was a systems error and RN5 stated not as she was the only nurse with the medication errors. On 08/09/23 at approximately 08:00 AM during record review it was noted RN6 charted she notified R263'S doctor, pharmacist, and wife of the medication error.	F 760	9/4/23. As part of the in-service training, all insulin for all residents will be double checked with the other nurse on shift prior to injection to reduce possibility of error. The Nurse Educator, Assistant Director of Nursing and Director of Nursing will periodically conduct med pass observation with the nurses to ensure compliance with proper medication pass procedures. The goal of ongoing in-service training, med pass observation is to ensure that all residents are consistently receiving the proper medications at the time indicated in the orders. The Assistant Director of Nursing, Nurse Educator and Director of Nursing are responsible for this action and working with the licensed nurses to ensure that all residents are protected from medication errors.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F 761		9/8/23

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 761	Continued From page 26 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to assure a resident's insulin was labeled with the discard by date. Findings include: On 08/09/23 at approximately 11:25 AM Registered Nurse (RN)5 brought out Resident (R)263's insulin pen from the medication cart. The label of the insulin pen documented the open (first use) date of 08/06/23. There was no documentation of the discard date, the line was left blank. RN5 confirmed the discard by date	F 761	Staff in-service training was conducted by the Nurse Educator for all licensed nurses regarding the proper labeling of medications including insulin, eye drops and other items. The training included labeling the date opened, storage and discard date. The training was conducted on August 22, 23, 24, 25, 27 and 30 and September 4th to ensure all staff had the opportunity to attend. The Assistant Director of Nursing and Nurse Educator audited medication and treatment carts on 8/22/2023 to ensure that all medication	

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 761	Continued From page 27 had not been written. When questioned how long the insulin pen can be used RN5 stated she would check with her supervisor, that she did not want to say the wrong answer. RN5 returned and stated the supervisor said, "4 weeks". RN5 was able to calculate the discard by date from the open date.	F 761	are being properly labeled with open and discard dates. All licensed nurses are responsible for labeling medications when opened and when to discard following pharmacy recommendations. Random audits will be performed by the Assistant Director of Nursing and the Nurse Educator to ensure compliance.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure food items were stored under sanitary conditions and the sanitizing solution was at the appropriate concentration for the three compartments sink.	F 812	In-service training was completed by the Registered Dietitian and Dietary Supervisor on August 28,29,30 and 31 with Dietary/Kitchen staff regarding the procedures, policies and proper methods to follow when when storing/covering food	8/21/23

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 812	Continued From page 28 Findings include: On 08/08/23 at 08:05 AM an initial tour of the kitchen was done with Registered Dietitian (RD). In the walk-in refrigerator observed food items were stored without a cover: tray of cooked salmon, one pie atop clear wrap of a metal container, and metal container of cooked pearl onions (labeled as prepared on 08/07/23). Observation in another walk-in refrigerator found a rack storing several metal pans with a total of 12 blueberry pies and a rack with four trays of cooked beef with a label documented preparation date of 08/07/23 (there were three refrigeration fans above the rack) that were not covered. RD reported the items that were not covered was placed in the refrigerator to cool down after cooking. Noted cooked onion and beef were labeled with a preparation date of 08/07/23 and there were no labels of when the other food items were prepared/cooked. In the dry storage, observed a plastic container of champagne vinegar labeled with an open date of 06/14/23 and discard date of 06/30/23. The RD reported the staff that labeled the vinegar was probably following rule to discard food after 14 days. However, RD stated vinegar has a longer shelf life than 14 days. Observed a large plastic container of powder for thickening liquids. Although the handle of the scooper was not in the powder, the RD confirmed the scooper should not be in the container. A request was made to check the sanitizing solution at the three-compartment sink located at the back of the kitchen. Observed there were no test strips available at the sink or a log to	F 812	items, properly labeling, dating (including discard dates), as well as ensuring the scooper for thickener should not be left in the container. Each dietary staff assigned to the auxiliary kitchens are responsible for ensuring compliance. Random audits will be conducted by the Registered Dietitian and Dietary Supervisor for compliance with covering, labeling and discarding unused food items and ensuring scooper for thickener is not left in the container. In the main kitchen, the lead cook will ensure compliance with food safety requirements.Random audits will be conducted by the Chef D'Cuisine and Sous Chef regarading above. The Director of Dining Services will also conduct independent random audits of the food safety requirements. An additional in-service was completed by the Chef D'Cuisine for all dishwashers regarding the keeping of sanitizing logs, the proper testing of the three compartment sink, including trouble shooting if sanitation issue arise. The lead cook and Chef D'Cuisine will audit the three compartment sink logs weekly and will also in-service newly hired dishwashers accordingly. In-service training for the Dishwashers was conducted on August 18, 19, 20 and 21.	

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 812	Continued From page 29	F 812		

document the findings of testing. Inquired what kind of solution is (i.e., chlorine, quaternary based) was used to sanitize the dishes. The RD checked the plastic container under the sink. A Kitchen Staff (KS)5 member provided a container of test strips. KS5 reported the strips are stored in the office. KS5 dipped the test strip in the sanitizing solution. Then compared the color of the strip with the manufacturer's color guide to determine whether the solution was at the correct parts per million (ppm). KS5 held the strip to the container and stated it was between colors. Further queried what are the acceptable ppm for this solution. The staff member looked at the manufacturer's container and stated 272 to 700 ppm. Further queried based on the color of the strip that was dipped into the sanitizing solution, is the solution within acceptable parameters. Staff member was unable to confirm. Requested a copy of logs with test results for the three-compartment sink.

On 08/09/23 at 11:01 AM a follow-up visit to the kitchen was done. Interview with Sous Chef confirmed there is no log to document the test results of the sanitizing solution of the three-compartment sink. The Sous Chef checked the level of the sanitizing solution and stated the concentration was too strong.

A review of the facility's policy and procedures, titled "Labeling Food Items" noted guideline, "At the time foods are removed from hot or cold holding and placed in a container, DATE WITH PREPARATION DATE AND THE DATE THAT IS TO BE USED OR DISCARDED".

A review of the facility's policy and procedures, titled "Sanitation Workstation (three-

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 812	Continued From page 30 compartment sink) to maintain proper levels and ratios of sanitation solution to ensure all non-porous food contact surfaces and utensils are properly disinfected and safe from chemical contamination was done. The procedures included: "designated test strips are to be used to check the sanitation solution's concentration i.e. ppm color guide on test strip bottle matches what is shown on test strip (sanitation solutions must be corrected by adding more water or sanitation solution if concentration is above or below the acceptable ppm range; sanitation solution in 3 compartment sink must be discarded and replaced every 4 hours; and three-compartment sink log must be completed and signed daily to document the sanitary solution is at the correct concentration and used for duration of less than/greater than 4 hours". Attachment included a form for documentation of testing the 3 compartments sink with the parameters indicated at 272 to 700 ppm.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		9/11/23

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 880	Continued From page 31	F 880		

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 880	Continued From page 32 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide a safe, sanitary, and comfortable environment to prevent the development and transmission of communicable diseases and infections. Resident (R)263's drained bile from R263's gallbladder was left out in the resident's room and not discarded appropriately. Findings include: R263 was admitted the facility on 08/04/23 with diagnoses of Alzheimer's Dementia and acute cholecystitis requiring colostomy care. On 08/09/23 at 11:45 AM concurrent observation and interview with Registered Nurse (RN)5 was done. Observed one ounce of dark yellow liquid substance in a container partially closed on R263's nightstand. Inquired with RN5 what the substance was and after RN5 looked at the substance she stated she was not sure, she later stated it was bile from R263's colostomy drainage bag. RN5 reported the nightshift usually removes the bile from the drainage bag and discards the bile in the toilet and flushes the toilet after.	F 880	Training was conducted by the Nurse Educator/Infection Preventionist with all licensed nurses and CNAs regarding proper disposal of blood and bodily fluids. Random room rounds and observation will continue to be done by the Nurse Educator/Infection Preventionist to ensure compliance with the proper handing and disposal of blood and bodily fluid items. Training was conducted on August 9, 22, 23, 24, 25, 27, 30 and Septemner 4th to ensure all staff had the opportunity to attend.	

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 _____	08/10/2023

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

(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) COMPLETION DATE
F 880	Continued From page 33 On 08/10/23 at 10:05 AM interview with Infection Preventionist (IP) with Director of Nursing (DON)was done. IP reported when discarding a drainage bag with resident's bile staff are to discard it in the resident's toilet. If the bile was put into a sample container it should be discarded along with the container. Inquired the reason it should be discarded and not left on the resident's bedside table; IP stated "it is infection control issue. We don't want to leave bile out in the open like that. Review of the facility's policy and procedure number DH-042 "Infection Control" revised on March 16, 2020, documented "All body and blood fluids will be considered infectious..."	F 880		