STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125066	A. BUILDING ______ B. WING ______	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KALAKAUA GARDENS	1723 KALAKAUA AVENUE HONOLULU, HI 96826

(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 06/13/23 - 06/16/23. The facility was found not to be in substantial compliance with 42 CFR §483, Subpart B. One facility-reported incident (FRI) was investigated (ACTS #9724). There were no deficient practices cited related to the FRI investigation. Survey Dates: 06/13/23 - 06/16/23 Survey Census: 41	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in	F 561		7/7/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 06/29/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125066	A. BUILDING ______ B. WING ______	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KALAKAUA GARDENS	1723 KALAKAUA AVENUE HONOLULU, HI 96826

(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 561

Continued From page 1

community activities both inside and outside the facility.

§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.

This REQUIREMENT is not met as evidenced by:

Based on interviews and record reviews, the facility failed to facilitate resident self-determination through support of resident choice for two residents (R), R48 and R217, out of five residents at the resident council meeting. The facility did not disclose the rehabilitation treatment times to R48 and R217 rendering them unable to plan for visits, activities, and appointments for their day and to worry about their therapy treatment time .

Findings include:

On 06/14/23 at 11:32 AM, conducted the resident council meeting. R48 stated that she would like to know when her rehabilitation sessions for physical therapy (PT) will be because she doesn't want to "wait all day for them." R48 further stated that she cannot plan her appointments for the day because she doesn't know what time the therapist will arrive. R217 also stated that he would like to know his rehabilitation therapy time for PT so that he can prepare himself beforehand and be in the right mindset to work hard with PT so that he can be ready when he goes home.

Record review of R48's and R217's current care plans. Under the focus for "PSYCHOSOCIAL" an intervention stated, "Provide the resident with as

F 561

R48, was discharged from the facility on 06/17/2023. R217 was discharged from the facility on 06/24/2023.

The Administrator in-serviced the Director of Rehab (DOR) on residents preferred therapy times on June 27, 2023, and F561 Self-Determination regulation.

This deficient practice could affect all residents who have orders for therapy.

The Director of Rehab, Dietary, Activity Director, Social Service Director, Registered Dietician, and a representative from nursing will meet with current residents and new admissions regarding their preferred time frames for therapy during their care plan meeting. The Director of Rehab started on June 27, 2023, to communicate to therapy staff the residents preferred therapy times.

Starting July 7, 2023, an audit will be conducted by the Director of Rehab/Designee by using the F561 Self-Determination monitoring tool for 3 months. The Director of Rehab/Designee will select a total of 3 residents from the 4th and 5th floor and ask the resident if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125066	A. BUILDING ______ B. WING ______	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KALAKAUA GARDENS	1723 KALAKAUA AVENUE HONOLULU, HI 96826

(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 561	Continued From page 2 many situations as possible which give the resident control over the resident's environment & care delivery." Reviewed facility's policy and guidelines for "RESIDENT RIGHTS Right to Self-Determination Number 561," dated 07/2018. It stated, "...1. The resident has the right (sic) choose activities, schedules (including waking and sleeping times), health care and providers of health care services consistent with his or her interests, assessments and plan of care." On 06/16/23 at 08:25 AM, interviewed the Director of Rehab (DOR). DOR stated for continuity of care he tries to assign the same therapy staff to work with the same residents. DOR further stated that there is no set process to notify residents of their treatment times, some therapists will see the resident in the morning and inform them what part of the day their session will be done. There are other therapists that will not notify their residents ahead of time and will just show up. DOR confirmed that the therapists should communicate more with the resident and see the resident in the morning to notify them of their treatment time for the day. On 06/16/23 at 08:57 AM, the Administrator was interviewed. Administrator agreed that residents have the right to know what their scheduled therapy session time is to be.	F 561	therapy session is held based on their preferred time. Any findings will be corrected immediately. The results will be reported to the Quality Assurance and Performance Committee to determine if ongoing monitoring and correction actions are necessary.	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and	F 623		7/7/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125066	A. BUILDING ______ B. WING ______	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KALAKAUA GARDENS	1723 KALAKAUA AVENUE HONOLULU, HI 96826

(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 623		F 623		

Continued From page 3
the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125066	A. BUILDING ______ B. WING ______	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KALAKAUA GARDENS	**1723 KALAKAUA AVENUE HONOLULU, HI 96826**

(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 623	Continued From page 4	F 623		

(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125066	A. BUILDING ______ B. WING ______	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KALAKAUA GARDENS	1723 KALAKAUA AVENUE HONOLULU, HI 96826

(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 623	Continued From page 5 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide written notice of transfer or discharge for two of the four residents (R) sampled (R24 and R48) for discharge, who were transferred to an acute care hospital for a higher level of care. The facility failed to provide notice to the residents or the residents' representative(s) and to the Office of the State Long-Term Care Ombudsman (LTCO). Findings include: 1) Resident (R)24 is a 68-year-old female admitted to the facility on 04/26/23. On 05/11/23, R24 was transferred to the emergency room and admitted to the acute care hospital. A review of R24's electronic health record (EHR) was done on 06/14/23 at 01:46 PM. No documentation was found that written notification of transfer/discharge was provided to the resident or her representative. On 06/15/23 at 11:39 AM, an interview was done with the Social Services Director (SSD) in the third floor conference room. SSD confirmed that a transfer/discharge notification had not been provided to the resident or her representative.	F 623	Resident #R24 discharged on 5/11/23 to an acute care setting. No notice was provided at the time of transfer and the resident was not readmitted. The State Long-Term Care Ombudsman was notified of R24□s discharge via fax sent on 5/11/23. Resident #48 was provided the reason for transfer/discharge in writing by the Social Services Director on 5/15/23 and understanding was verified and documented. The State Long-Term Care Ombudsman was notified via fax sent on 6/19/23. The facility has determined that all residents who have been transferred or discharged have the potential to be affected. An in-service education program was conducted by the Administrator with the Director of Social Services and IDT team members on 6/27/23 addressing circumstances regarding required notices for residents upon transfer and discharge from the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125066	A. BUILDING ______ B. WING ______	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KALAKAUA GARDENS	1723 KALAKAUA AVENUE HONOLULU, HI 96826

(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 623

Continued From page 6

SSD shared that until recently, she was unaware that transfers to the acute care hospital required written notification.

2) R48 is a 77-year-old female admitted to facility on 04/21/23 for short-term rehabilitation after being discharged from the hospital following transcatheter aortic valve replacement (replacement of a valve in the heart through the blood vessel). On 06/14/23 at 02:28 PM, review of the EHR revealed that R48 was transferred to an acute care hospital on 05/06/23 and 05/19/23 for complications from the surgical site. Documentation of the bed-hold agreement was found in the EHR but not the documentation of notification to the resident or resident's representative and to the LTCO.

On 06/14/23 at 03:29 PM, requested copies of the discharge notifications for R48 and facility policy on transfer of residents from the Administrator. Facility's policy on admission, transfer and discharge was provided but not the discharge notification for R48.

On 06/15/23 at 01:39 PM, interview with SSD was conducted in the conference room. Asked SSD if the resident or resident's representative and the LTCO were provided written notification when R48 was transferred to an acute care hospital. SSD confirmed that notifications were not sent for both transfers because she has just recently been made aware that it was required. SSD added that moving forward, she will send the notifications for residents transferred to the hospital.

Review of facility policy, "Admission, Transfer and Discharge Notice Requirements Before

F 623

For a period of 3 months, the Social Service Director or designee will conduct an audit of all residents who have been transferred or discharged from the facility to ensure the record includes a copy of the transfer/discharge notice. At the time of the notice delivery, the Social Services Director will ensure that they have received a transfer/discharge notice written in a language that they can understand. A transfer/discharge list will be sent to the State Ombudsman Office via fax as soon as practicable and at least monthly. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125066	A. BUILDING ______ B. WING ______	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KALAKAUA GARDENS	1723 KALAKAUA AVENUE HONOLULU, HI 96826

(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 623	Continued From page 7 Transfer/Discharge" dated 07/2018 stated: " ... 14. An emergency transfer to an acute care facility, is a facility-initiated transfer and a notice must be provided to the resident/representative as soon as practicable. ... 15. Emergency transfer notifications will be sent to the Ombudsman on at least a monthly basis."	F 623		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents'	F 726		7/7/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125066	A. BUILDING ______ B. WING ______	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KALAKAUA GARDENS	1723 KALAKAUA AVENUE HONOLULU, HI 96826

(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 726	Continued From page 8 needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews (RR), the facility failed to ensure staff had the knowledge to provide care, coordinate, and respond to the individualized needs for one resident (R)35 out of two residents sampled for hospice care. This lack of knowledge and coordination was evident as facility staff were unsure of the delineation of hospice responsibilities, hospice visit schedule, and other hospice services necessary for care of the resident's terminal illness and related conditions. This deficient practice created a potential for physical and psychosocial harm. Findings include: R35 is a 78-year-old male receiving hospice services with diagnoses of rectal cancer, prostate cancer, neuromuscular bladder dysfunction with urinary retention, iron deficiency anemia, severe protein-calorie malnutrition, high blood pressure, high cholesterol, and repeated falls. On 06/13/23 at 09:46 AM, observed R35 in bed. R35 stated that he was in almost constant pain in his lower abdomen and rectum. R35 stated that his pain is generally controlled with his current medication regimen, but he winced periodically as he shifted in bed throughout the observation. R35 was unsure of how often hospice staff come to evaluate and treat him or of his hospice plan of care. On 06/15/23 at 09:40 AM, interviewed Registered Nurse (RN)1 regarding R35's hospice care plan	F 726	On June 28, 2023, the Social Service Director spoke to R35, and the resident informed of the hospice schedule. This deficient practice could affect all residents who have services for hospice. The license nurse training was started on June 27, 2023, by the DON/ADON/Designee regarding F726 Competent Nursing Staff with instruction on the hospice binders, location and contents to include the care plans and the hospice schedule. Hospice binders are at the nurse□s station for each resident. The facility license nurses and hospice nurse will use the binders to assist in collaboration of plan of care for residents receiving hospice services. The licensed nurses were informed that Medical Records and Social Services would be responsible for maintaining the hospice binders with assistance from designated hospice agencies. The Social Service Director/designee will be responsible for letting the residents know their hospice schedule during the care plan conference and as needed. Medical Records, Social Services and MDS Coordinator received training by the DON on June 27, 2023, regarding maintaining the hospice binders. The Social Service Director was trained by the DON on June 27, 2023, regarding their responsibility of notifying the resident of their hospice schedule.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125066	A. BUILDING ______ B. WING ______	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KALAKAUA GARDENS	1723 KALAKAUA AVENUE HONOLULU, HI 96826

(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 726	Continued From page 9	F 726		

and treatments. RN1 was unsure of how often hospice staff visited R35 but thought, "about twice a week." When asked how nursing staff know hospice responsibilities for R35, RN1 stated that hospice responsibilities should be "in the hospice care plan." RN1 could not find the hospice care plan in R35's electronic health record (EHR) but stated, "The hospice plan should also be in the [hospice] binder at the nurses station."

On 06/15/23 at 01:19 PM, conducted interview with Licensed Practical Nurses (LPN)1 and LPN2 at the nurses station. Neither LPN1 or LPN2 were able to identify R35's hospice care plan in R35's EHR or the hospice binders at nurses station.

On 06/16/23 at 08:30 AM, conducted concurrent interview and RR with LPN3. LPN3 stated that hospice comes, "maybe once a month, but I think it's twice a week and we can always call them." LPN3 could not find R35's hospice care plan in the EHR and stated that it should be in the hospice binder at the nurses station, however LPN3 could not find it there.

On 06/16/23 at 08:35 AM, conducted concurrent interview and RR with the hospice nurse. The hospice nurse located the hospice care plan in the most recent hospice nursing progress note but stated that the care plan should be more clearly labeled for better reference and coordination of care.

On 06/16/23 at 11:20 AM, conducted RR of facility policy and procedures (PP) for Hospice dated 07/18. The PP documented, "The facility and the hospice will establish a coordinated plan of care which identifies the specific services/ functions each provider is responsible for

Provider's Plan of Correction (F 726):

Hospice agencies as of June 27, 2023, have been contacted by Social Service/designee to ensure collaboration of resident care between services.New staff members or agency not present during training days will receive training prior to or during their next scheduled shift.

The facility will monitor licensed nurses knowledge on location and contents of the hospice binders to include hospice care plans and schedule. Starting July 7, 2023, the DON/ADON/designee will use the "F726 Competent Nursing Staff monitoring tool" for 3 months and interview a total of 3 nurses from 4th and 5th floors regarding the location of hospice binders and contents. Any findings will be corrected immediately. The results will be reported to the Quality Assurance and Performance Committee to determine if ongoing monitoring and correction actions are necessary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125066	A. BUILDING ______ B. WING ______	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KALAKAUA GARDENS	1723 KALAKAUA AVENUE HONOLULU, HI 96826

(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 726	Continued From page 10 performing." RR of facility licensed nurse competencies, orientation packet for temporary personnel, and orientation checklist for agency staff did not document education in hospice services or care.	F 726		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs	F 755		7/7/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125066	A. BUILDING ______ B. WING ______	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KALAKAUA GARDENS	1723 KALAKAUA AVENUE HONOLULU, HI 96826

(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 755	Continued From page 11	F 755		

is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on interviews and record reviews (RR), the facility failed to ensure safe and secure storage/disposal of Fentanyl, a pain medication that is a narcotic and controlled medication, to minimize loss or diversion. This deficient practice has the potential for the medication to be obtained and used illegally.

Findings include:

On 06/15/23 at 09:42 AM, inspected a medication cart with Registered Nurse (RN)1. While reconciling controlled medications, RN1 stated that Resident (R)35 had fentanyl patches in the cart with current physician orders. When asked to describe the process of wasting a fentanyl patch due to damage, contamination or other reason, RN1 stated, "I would get another nurse to verify, then fold the patch up, cut it into pieces, and put it in the sharps [puncture-proof biohazard disposal] container." When asked how to dispose of used fentanyl patches, RN1 described disposing of used fentanyl patches by removing the patch from the resident, folding the sticky portions of the patch together, and discarding in the biohazard sharps container on the medication cart.

On 06/15/23 at 10:05 AM, RR of R35's Electronic Health Record (EHR) physician order documented:
"fentaNYL Transdermal Patch 72 Hour 12 MCG [micrograms]/HR [hour]
(Fentanyl) Apply 1 patch transdermally [medication absorbed through the skin] every 72 hours for Pain and remove per schedule

Provider's Plan of Correction:

The License Nurses training was started by the DON/ADON on June 27, 2023, on the procedure how to safely dispose of R35's, fentanyl patches.

This deficient practice would affect all residents who have orders for fentanyl patch. An audit was conducted by the DON and ADON on June 27, 2023, and there were no other residents with fentanyl orders.

The License Nurses training started by the DON/ADON on June 27, 2023, on how to safely dispose of fentanyl patches.
The procedure:
a. Two license nurses must be present for the destruction of the fentanyl patch. Nurse 1 will apply gloves to prepare for destruction. Nurse 2 will witness the destruction.
b. Nurse 1 will fold the fentanyl patch in half so that the adhesive side is stuck together. Nurse 2 is present as a witness.
c. Nurse 1 will place the folded fentanyl patch into the Drug Buster container. Place the lid on the container, invert and swish the bottle twice. (A Drug Buster, charcoal disposal system which turns control substance fentanyl patch into a non-hazardous non-toxic slurry).
d. Nurse 1 after fentanyl patch destruction will remove gloves and wash hands.
e. Nurse 1 and Nurse 2 will complete drug destruction forms.
New staff members or agency not present

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125066	A. BUILDING ______ B. WING ______	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KALAKAUA GARDENS	1723 KALAKAUA AVENUE HONOLULU, HI 96826

(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 755	Continued From page 12	F 755		

Order Active 06/08/2023; Started 06/08/2023."

Review of R35's electronic Medication Administration Record (MAR) documented a fentanyl patch had last been applied on 06/14/23 at 01:10 PM and was scheduled to be removed on 06/17/23 at 01:19 PM.

On 06/15/23 at 10:20 AM, reviewed facility's policy and procedure (PP) for "Pharmacy Services Controlled Medications" dated 11/17. The PP documented, "Facility follows pharmacy specific guidelines and state requirements for destruction of controlled medications. Disposal methods for controlled medications involves a secure and safe method to prevent diversion and/or accidental exposure." The PP did not document a specific method or process to dispose of controlled medications.

On 06/15/23 at 11:24 AM, interviewed the Director of Nursing (DON) and the Assistant Director of Nursing (ADON). The ADON stated that the procedure for disposal of used fentanyl patches was to fold the patch on itself, place in a bin with a chemical to neutralize any medication in the patch and dispose of the residue by double-bagging and discarding in the trash. The DON stated that orders for controlled medications were recently revised to include two-nurse verification of patch placement and wasting of fentanyl patches, but that staff education had not yet been conducted and was scheduled for the upcoming staff education meeting.

On 06/16/23 at 09:40 AM, interviewed the pharmacy manager. The pharmacy manager stated that controlled medications should be disposed of using either a reverse distributor

during training days will receive training prior to or during their next scheduled shift.

The facility plans to monitor fentanyl patch drug destruction. Starting July 7, 2023, the DON/ADON/Designee will audit the drug destruction for fentanyl patch for 3 months using the F755 Fentanyl Destruction monitoring tool. The audit will check to validate the fentanyl patch destruction was completed by 2 nurses, adhesive side of fentanyl patch was folded in half, and fentanyl patch was destroyed in the Drug Buster container. Any findings will be corrected immediately. The results will be reported to the Quality Assurance and Performance Committee to determine if ongoing monitoring and correction actions are necessary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125066	A. BUILDING ______ B. WING ______	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KALAKAUA GARDENS	1723 KALAKAUA AVENUE HONOLULU, HI 96826

(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 755	Continued From page 13 service, using a chemical agent to neutralize medications, or flushing medications down the toilet per EPA (Environmental Protection Agency) guidelines. The pharmacist confirmed this process should be the same for fentanyl patches being wasted and for used fentanyl patches as "they still contain some medication."	F 755		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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, interview, and record	F 761	R54 Novolg insulin pen was discarded on	7/7/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125066	A. BUILDING ______ B. WING ______	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KALAKAUA GARDENS	1723 KALAKAUA AVENUE HONOLULU, HI 96826

(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 14

review, the facility failed to ensure all medications used in the facility were labeled appropriately including clearly identified discard dates. Proper labeling of medications is necessary to promote safe administration practices, and to decrease the risk of medication errors. This deficient practice has the potential to affect all residents in the facility taking medications.

Findings include:

1) On 06/15/23 at 08:19 AM, an inspection of the fourth floor medication cart on the A side was done. Noted two Novolog insulin pens in a brown pharmacy bag for Resident (R)54. One of the insulin pens had a date opened/date to discard sticker where the date opened was left blank and the date to discard had "5/15/23" written in it. The label sticker also indicated that the insulin pen was to be discarded 28 days after opening.

On 06/15/23 at 08:28 AM, an interview was done with licensed practical nurse (LPN)1 in front of the medication cart. LPN1 confirmed that the date to discard read "5/15/23," and agreed that whether that was the date opened or the date to discard, the insulin pen should have been discarded and did not belong in the cart. Also confirmed at this time by LPN1 was that there was already a replacement Novolog insulin pen in the same bag. LPN1 immediately placed the old insulin pen into the sharps container on the cart to ensure that no one used it.

2) On 06/15/23 at 09:53 AM, observed a nursing unit's medication room. The refrigerator contained an open vial of multi-dose Tubersol (medication used to test for tuberculosis) 5 TU (tuberculin units) in an 0.1 ml (milliliter) vial.

F 761

6/15/2023 by (LPN) 1 per facility policy and procedures. The Tubersol vial was also discarded on 6/15/2023 by ADON per facility policy and procedure. A new vial was ordered and received by the facility.

This deficient practice would affect all residents who have orders for insulin and Tubersol.

Walking rounds were completed on June 27, 2023 by the DON/ADON, all insulin in med carts and refrigerators were checked and insulin and Turbersol vials have open and discard dates. The License Nurses received training by the Director of Nurses and/or Assistant Director/Designee on June 27, 2023, on the facility labeling policy for open dates and discard dates for insulin and Tubersol and how to find discard dates. Instructions will also be given to use the "Did you know" information located in narcotic binders placed on each medication cart which discloses the discard dates for medications i.e., insulins and Tubersol. On June 27, 2023, the facility pharmacy discard dates for insulin and Tubersol was placed in the narcotic binders on each of the four medication carts on 4th and 5th floor for License Nurses to use as a reference when working. New staff members or agency not present during training days will receive training prior to or during their next scheduled shift.

The facility plans to monitor the open date and discard dates for insulin and Tubersol. Starting July 7, 2023, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125066	A. BUILDING ______ B. WING ______	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KALAKAUA GARDENS	1723 KALAKAUA AVENUE HONOLULU, HI 96826

(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 15 There was a sticker on the box to input the date the vial was initially opened and the date of discard, which is 30 days after the opening date. The dates were not written on the spaces provided. On 06/15/23 at 10:00 AM, a concurrent observation of the Tubersol vial and box and interview was done with the Assistant Director of Nursing (ADON). ADON stated that the nurse who initially accessed the vial should have documented the date the vial was first opened and the discard date (expiration date) so that the medication would not be used past this date. Documentation of the Tubersol administered to the resident includes the date of expiration of the medication and this cannot be done if it is not documented on the sticker placed on the box. Record review of the facility's policy, "PHARMACY SERVICES Labeling and Storage of Drugs and Biologicals" dated 11/2017. It stated, "...8. If a multi-dose vial has been opened or accessed (e.g., needle-punctured), the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial..." Received via email from the Director of Nursing (DON) on 06/20/23 and reviewed PharMerica education sheet for "Medication Storage: Abridged Guidance for Select Medication" dated March 2023. It stated for the medication, "Tubersol Injection" that the vials of medication should not be used after 30 days due to the risk of "possible oxidation and degradation which may affect potency."	F 761	DON/ADON/designee will audit by using the "Medication Use by Date and Discard Date - Insulin monitoring tool" for a total of 3 months. The audit will check for the following: a. open date on insulin pen/vial b. discard date on the insulin pen/vial c. vial or pen d. name of person conducting the audit e. date of audit A second audit will be completed using the Medication Use by Date and Discard Date Tubersol monitoring tool for a total of 3 months. The audit will check for the following: e. open date on Tubersol vial f. discard date on the Tubersol vial g. name of person conducting the audit h. date of audit Any findings will be corrected immediately. The results will be reported to the Quality Assurance and Performance Committee to determine if ongoing monitoring and correction actions are necessary.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		7/7/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125066	A. BUILDING ______ B. WING ______	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KALAKAUA GARDENS	1723 KALAKAUA AVENUE HONOLULU, HI 96826

(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 16

§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 and staff interviews, the facility failed to follow safe food storage requirements. This deficient practice has the potential to affect all residents, visitors and staff who have meals served by the facility, placing them at risk for food-borne illnesses.

Findings Include:

On 06/13/23 at 08:31 AM, initial tour and observation of the kitchen area was conducted with the Food Service Manager (FSM). While checking the contents of the refrigerator by the food preparation area, noted an unlabeled black container on the top shelf. FSM immediately removed the container and said, "that's not supposed to be there." The container was

F 812

No specific residents were identified with the deficient practice.

The facility identified that all residents have the potential to be affected.

Dining staff were in-serviced on 6/27/23. Any staff not present at the initial in-service will be in-serviced at their next shift until all employees have been trained on proper food storage. Employee beverages are to be kept in designated location and to be covered to prevent cross contamination. Food deliveries will be placed 6 inches above the ground and put away upon delivery. All food will be stored covered and sealed to prevent food

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125066	A. BUILDING ______ B. WING ______	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KALAKAUA GARDENS	1723 KALAKAUA AVENUE HONOLULU, HI 96826

(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 17 identified as a water bottle that belonged to one of the kitchen staff. At 08:45 AM, entered the walk-in refrigerator and freezer with FSM. Noted two plastic bags of meat placed in a metal container without a cover. The plastic was not completely closed leaving the meat exposed to the environment. FSM identified the meat as pork and said it would be cooked today for lunch and that was why it was uncovered. In the walk-in freezer, noted two stacks of boxes containing frozen juice and another stack of boxes containing cut potatoes placed directly on the floor. FSM said the items were just delivered earlier that day and that he would remove them off the floor immediately. On 06/15/23 at 10:13 AM, follow-up observations were conducted in the kitchen area with the Executive Chef (EC). Noted a box of vegetables in the walk-in refrigerator and two boxes of frozen juice in the walk-in freezer placed directly on the floor. EC immediately moved the boxes off the floor and said, "they were just delivered but they are not supposed to be on the floor." Review of the facility's "Dietary Guideline Manual - Food Storage" revealed under "16. Refrigerated Food Storage: ... f. All foods should be covered, labeled and dated .... i. All foods will be stored off the floor." And "17. Frozen Foods: ... k. All foods will be stored off the floor."	F 812	contamination. Training will be conducted on proper food storage policies and procedures upon hire for new staff, annually and as needed for all employees. Food Service Manager or designee will monitor employee beverages, food storage and delivery areas and will ensure compliance through an audit three times weekly for the first month and then weekly for the next two months. Any findings will be immediately be corrected and audit results will be reported at the monthly QAPI meetings until consistent substantial compliance has been met.	
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	F 880		7/7/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125066	A. BUILDING ______ B. WING ______	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KALAKAUA GARDENS	1723 KALAKAUA AVENUE HONOLULU, HI 96826

(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 18	F 880		

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:

§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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125066	A. BUILDING ______ B. WING ______	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KALAKAUA GARDENS	1723 KALAKAUA AVENUE HONOLULU, HI 96826

(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 19 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 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 observations, interviews, and policy review, the facility failed to ensure proper hand hygiene procedures were followed by all staff members. This deficient practice increases the risk for the development and transmission of communicable diseases and infections. Findings include: Concurrent observation and interview were conducted on 06/16/23 at 08:10 AM with Housekeeper (HK)1. HK1 was observed on the fifth-floor walking around with gloves on both hands. HK1 was observed walking down the hallway towards the nurse's station. At the nurse's station, HK1 was observed touching the	F 880	HK1 was trained by a facility licensed nurse on June 16, 2023. HK1 received instructions not to wear surgical gloves in the hallway and policy and procedures of handwashing and when to discard gloves when in isolation rooms. This deficient practice could affect all residents which could place facility at risk for infections. Facility staff training was started by the DON/ADON/Designee on June 27, 2023, on the F880 Infection Prevention specific to CDC, Personal Protective Equipment (PPE) - pertaining to the removal of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125066	A. BUILDING ______ B. WING ______	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KALAKAUA GARDENS	1723 KALAKAUA AVENUE HONOLULU, HI 96826

(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 20	F 880		

windowsill and wall railings. HK1 then left the nurse's station and walked around the hallway towards the laundry area. HK1 then turned around and walked into room 513-B. HK1 pulled open the curtains with her gloved hands and entered the room. HK1 proceeded to talk to the resident for two minutes then exited the room. Throughout the observation HK1 did not remove her gloves. HK1 was stopped in the hallway and asked if she was supposed to have her gloves on her hands while walking around the hallway and entering residents' rooms. HK1 replied, "I just filled the cart and forgot to remove it, but no one told me to remove my gloves while I'm in the hallway."

An interview was conducted with the Director of Nursing (DON) in her office on 06/16/23 at 08:58 AM. DON was asked if staff were allowed to walk around with their gloves on in the hallway and enter/exit residents' rooms without changing gloves or performing hand hygiene. DON answered, "no they are not supposed to."

Review of the facility's policy titled, "Competency check-using personal protective equipment," dated September 2017, indicated "remove personal protective equipment prior to leaving the room. Remove gloves. Turn gloves inside out as they are removed, one inside the other. Do not touch the outside of the gloves. Discard gloves in trash container."

gloves when working in isolation rooms and also not to wear surgical gloves when walking in hallways. New staff members or agency not present during training days will receive training prior to or during their next scheduled shift.

The facility will monitor PPE usage pertaining to gloves. Starting July 7, 2023, the DON/ADON/designee will conduct walking rounds by using the "Infection Control Rounds - glove" monitoring tool for a total of 3 months. The DON/ADON/Designee will observe a total of 3 staff members from 4th and 5th floor. Any findings will be corrected immediately. The results will be reported to the Quality Assurance and Performance Committee to determine if ongoing monitoring and correction actions are necessary.