STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125050	A. BUILDING _____ B. WING _____	R 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MALAMALAMA	6163 SUMMER STREET HONOLULU, HI 96821

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{F 000}	INITIAL COMMENTS An onsite revisit was conducted by the Office of Health Care Assurance on 11/15/23. Deficiencies cited as a result of the recertification survey conducted on 09/15/23 were not found to be corrected. The facility continues to not be in substantial compliance with program requirements at 42 CFR 483, Subpart B.	{F 000}		
{F 552} SS=E	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on record review (RR) and staff interview the facility failed to inform three of three residents reviewed for the use of psychotropic medications, Resident (R)3, R7, and R9, or the resident's representative, in advance, by the physician or other practitioner or professional, of the risks and	{F 552}	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice - R7 & R9 psychotropic medication consent forms were signed and filed into	12/6/23

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

Electronically Signed | 12/06/2023

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.

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{F 552}	Continued From page 1 benefits of taking medication such as an antidepressant or antipsychotic and alternative treatment options available. This deficient practice could affect all residents in the facility who are taking a psychotropic medication. Findings Include: On 11/14/2023 at 12:35 PM met with and interviewed Director of Nursing (DON). Inquired with DON if she is tracking those residents in the facility who are taking a psychotropic medication (i.e. antidepressant, antipsychotic or mood stabilizer) and she confirmed that she is. She stated that she had acquired five signed informed consents for residents to continue taking the psychotropic medication ordered. This was five residents out of the 17 residents on the list of residents currently taking a psychotropic medication provided by the DON. RR found R3, R7 and R9 are still taking a prescribed psychotropic medication without a signed consent to receive these medications. R3 is taking Quetiapine Fumarate (antipsychotic) 25 milligrams (mg) 1/2 tablet by mouth at bedtime for dementia with behavior hold if sleepy. DON did state R3's son wants to discontinue this medication. R7 is taking Citalopram HBR (antidepressant) 10 mg tablet give one and 1/2 tab by mouth one time a day for dementia with behavior disturbance which is given at 08:00 AM. R9 is taking Sertraline HCL (antidepressant) 100 mg tablet give one tablet by mouth one time a day for Huntingtons Disease which is given at 08:00	{F 552}	the residents medical records. - R3s quetiapine was discontinued on 11/15/2023 per sons request after a discussion with the Director of Nursing (DON). How the facility will identify other residents having the potential to be affected by the same deficient practice. - All residents have the potential to be affected by the same deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur - Verbal consent will be accepted from the responsible party if they are unable to sign the hard copy until a later time. The verbal consent will be documented in the residents medical record, and the consent form will be sent to the responsible party by mail or e-mail. - The Director of Nursing or designee will follow up with the responsible party regarding outstanding consent forms. - Once the signed consent form has been received by the facility, the form will be filed in the residents medical record. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes - The DON or designee will review new	

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{F 552}	Continued From page 2 AM. R9 also received Mirtazapine (antidepressant) 7.5 mg one tablet by mouth at bedtime for diagnosis of anorexia.	{F 552}	psychotropic medication orders on a weekly basis and verify that an informed consent was obtained. - Ongoing education will be provided for licensed nurses, which will include how to obtain consent from the resident/responsible party and documenting any verbal consent received. - The Administrator or designee will verify on a monthly basis that weekly reviews are conducted as scheduled. - Informed consent compliance rates will be monitored and reported during quarterly QAPI meetings.	
{F 578} SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives	{F 578}		12/6/23

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{F 578}	Continued From page 3 and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, and interview with staff member, the facility failed to ensure that one resident (R), R86, out of three residents sampled, was able to fulfil her right to make choices about her medical treatment by completing an Advance Health Care Directive (AHCD). This deficient practice could potentially cause harm to residents as they may be given medical treatment that they do not want. Finding includes: Review of R86's AHCD document was included in her medical chart but not completed and not signed by two witnesses or notarized as required for validity. Review of a facility document "Supervising Health Care Professional and Physician Certificate of Capacity for ICF (Intermediate Care Facility) or SNF (Skilled	{F 578}	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice - An audit was completed by the Social Work Designee (SWD) on 11/15/23 to record all residents without an Advanced Healthcare Directive (AHCD). - R86 expired on 11/24/2023. - Residents' medical records were reviewed by the SWD to ensure compliance with current AHCD requirements. How the facility will identify other residents having the potential to be affected by the same deficient practice. - All residents have the potential to be	

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{F 578}	Continued From page 4 Nursing Facility) Legal Surrogate Appointment" documented and signed by a physician that R86 "DOES...have the ability to make and communicate health care and financial decisions." On 11/14/23 at 01:32 PM interview with Social Worker (SW) was done. SW confirmed R86's AHCD was not completed, and the SW did not document the AHCD was offered to R86 to be completed.	{F 578}	affected by the same deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur - The AHCD was added to the admission checklist as an admission requirement. - The AHCD will be reviewed for completion and accuracy when a copy is provided to the facility. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes - The SWD will ensure compliance through medical record audits to be conducted weekly for a minimum of 12 weeks (about 3 months) or until substantial compliance has been achieved. - The results of these audits will be brought to the QAPI meeting for review and further recommendation for a period of 6 months or until sufficient compliance has been achieved.	
{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	{F 880}		12/6/23

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{F 880}	Continued From page 5 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 circumstances.	{F 880}		

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{F 880}	Continued From page 6 (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 and interviews, the facility failed to ensure proper hand hygiene procedures were followed by a staff member during a dressing change. This deficient practice promotes the development and transmission of communicable diseases and infections, and has the potential to affect all residents needing wound dressing change in the facility. Findings Include: Dressing change was observed on 11/15/23 at 11:43 AM in Resident (R) 3's room. Registered Nurse (RN) 1 was providing dressing change to four different wounds on R3's lower extremities. During the dressing change RN1 removed her gloves eight times and donned new gloves eight	{F 880}	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice - RN1 was given a copy of the wound care/dressing audit tool that had been previously covered during an October 2023 in-service. - The staffing agency that employs RN1 notified the facility that RN1 will not return to the facility as of 11/20/2023. - Hand hygiene and wound/dressing change audits are performed monthly. How the facility will identify other residents having the potential to be affected by the	

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{F 880}	Continued From page 7 times. The times RN1 performed glove change, RN1 did not perform hand hygiene. After the first glove change was observed without hand hygiene, RN1 was queried if she needed to perform hand hygiene prior to donning new gloves. RN1 answered that she had washed her hands prior to starting the dressing changes and her hands are still clean. Interview was conducted with the facility's Infection Control Coordinator (ICC) on 11/15/23 at 12:02 PM. The ICC stated that the training she provided for the staff included performing hand hygiene in between doffing and donning new gloves. ICC stated that RN1 should have been performing hand hygiene in between glove changes.	{F 880}	same deficient practice. - All residents have the potential to be affected by the same deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur - Audit tools for infection prevention and control topics were created and audits are conducted monthly at minimum. - Wound care/dressing changes are observed monthly to identify ongoing education needs. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, I.e., what program will be put into place to monitor the continued effectiveness of the systemic changes - Wound care/dressing change in-services for licensed nurses will be conducted annually or upon hire. The audit tools will be available for agency staff to review during the orientation period. - Hand hygiene and wound/dressing change audits are performed monthly. - Results of wound care/dressing change audits will be shared with the QAPI Committee and DON for further resolution or recommendation until the committee validates compliance is sustained.	