

STATE OF HAWAII
DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE ASSURANCE
601 KAMOKILA BOULEVARD, ROOM 361
KAPOLEI, HAWAII 96707

PRELIMINARY
REPORT OF ON-SITE VISIT

NAME OF FACILITY Hokulaki Senior Living, L.L.C. DATE 10/3/24 ANNUAL

Time In: 8:00a

Time Out: 2:30

Vacancy: 3

Resident #1 – Masamitsu Tateishi
Resident #2 – Margaret Moritsugu
SCG #1 – Samantha Cazin
SCG #2 – Gloria Santiago

11-100.1-15(e)

Resident #1 – Risperidone and Dulcolax suppository were discontinued by physician on 3/13/24; however, medication was not discontinued from MAR until 4/1/24

Resident #1 – Lactulose and Ipratropium-Albuterol Inhalation Solution were discontinued by physician on 9/4/24; however, medication was not discontinued from MAR until 10/1/24

Resident #1 – Physician’s order dated 12/11/23 and renewed every 3 months until current day (10/3/24) states, “Metoprolol Succinate ER (25mg tabs) 1 tablet po daily for HTN. *Hold for SBP<110, HR <55”; however, per MAR, medication has been administered twice daily from 12/1/23-present day (10/3/24)

Resident #1 – Physician’s order dated 9/4/24 states, “Metoprolol Succinate ER (25mg tabs) 1 tablet po daily for HTN. *Hold for SBP<110, HR <55”; however, between 9/24/24-9/30/24, medication was administered twice daily yet caregiver’s log shows blood pressure was only obtained once daily and hold parameter were not acknowledged before administering second dose.

11-100.1-15(m)


SURVEYOR'S SIGNATURE


OPERATOR'S SIGNATURE

Resident #1 – Physician’s note dated 6/17/24 states, “Last time diazepam used was a week ago and requires diazepam for sleep about 1-2 times a week”; however, MAR shows diazepam was never administered between 11/2023-present day (10/3/24)

11-100.1-16(h)

Resident #1 – Resident’s daily schedule activities states from 8:45a-9:00a resident should be “Walk/WC around house/Hallways”; however, resident observed watching TV in living room from 8:00a-12:00p

11-100.1-16(i)

Resident #1,2 – No documented evidence annual influenza vaccine was received or offered by facility

Resident #2 – No documented evidence pneumococcal vaccine was received or offered by the facility

11-100.1-17(b)(3)

Resident #1 – No documented evidence of changes in health condition leading up to ED visit on 8/29/24 for a UTI or monitoring of condition following antibiotic treatment

Resident #1 – Monthly progress notes unavailable from 11/2023-9/2024

Resident #1 – Physician prescribed special diet order of “Regular, Moist, Minced (for ease of swallowing); Nectar-Thickened Liquids”; however, no documented evidence of residents response to special diet in monthly progress notes from 11/2023-present day (10/1/24)

Resident #1 – No documented evidence of resident’s response to medications in monthly progress notes

11-100.1-17(c)

Resident #1 – Incidence report unavailable for resident visit to emergency department on 8/29/24

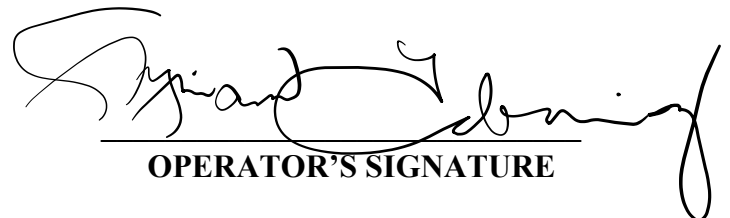
11-100.1-17(f)(4)

Resident #1 – Vital signs transcribed by PCG onto computer print out filed in resident’s record does not accurately reflect the caregivers’ vital signs noted on their vital sign log and additionally, appear to include a second set of falsified blood pressure and heart rate measurements.

- Caregiver’s vitals obtained VS PCG transcribed vitals
 - 9/24/24 – BP 135/71, HR 68 vs (am) BP 133/67, HR 70 and (pm) BP 125/60, HR 66
 - 9/25/24 – BP 156/68, HR 77 vs (am) 136/76, HR 68 and (pm) 134/73, HR 64
 - 9/26/24 – BP 147/56, HR 56 vs (am) 146/70, HR 71 and (pm) 139/70, HR 72
 - 9/27/24 – BP 129/63, HR 64 vs (am) 127/65, HR 68 and (pm) 142/72, HR 72
 - 9/28/24 – BP 115/49, HR 69 vs (am) 131/68, HR 65 and (pm) 136/70, HR 67
 - 9/29/24 – BP 167/79, HR 74 vs (am) 126/63, HR 68 and (pm) 139/68, HR 71
 - 9/30/24 – BP 112/62, HR 61 vs (am) 130/66, HR 67 and (pm) 137/80, HR 70

11-100.1-21(a)(1)(C)


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Resident #1 – Documented evidence rates for services was provided in writing at the time of admission

11-100.1-10(a)

Resident #2 – No level of care assessment by MD prior to admission. Level of care completed 2/5/24, almost 2 months after.

11-100.1-17(a)(4)

Resident #2 – Admission physical exam not available. PE done 2/5/24, 2 months after admission.

11-100.1-17(a)(4)

Resident #2 – No initial tuberculosis (TB) assessment upon admission. TB available was done 1/18/24, over 1 month after admission.

11-100.1-16(h)

Resident #2 – Program of activities not available for review.

11-100.1-17(a)(6)

Resident #2 – No diet order upon admission available, until 3/15/24. Resident was admitted 12/20/24.

11-100.1-17(a)(6)

Resident #2 – No medication order upon admission available. Medication order that PCG dated as 12/20/24 was not signed by MD until day of inspection on 10/3/24.

11-100.1-15(e)

Resident #2 – December 2023, January 2024, and February 2024 MAR observed with the following medications administered but no orders from MD to administer:

- Vitamin B12, 500mg
- Carvedilol 3.125mg
- Vitamin D3 2000 IU
- Levothyroxine 50mcg
- Losartan 50mg

11-100.1-15(e)

Resident #2 – 4/11/24 MD order to discontinue “Clomepramine 50mg tablets” however there were no MD order to administer the aforementioned medication. January 2024 MAR indicated that medication started on 1/24/24.

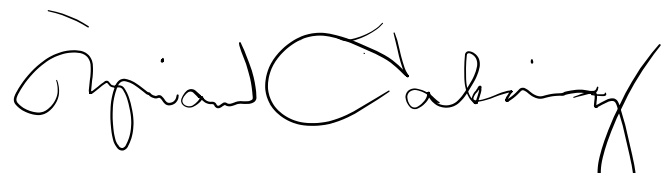
11-100.1-15(e)

Resident #2 – September 2024 MAR with “docusate sodium 50mg” was not initialed from 9/6/24-9/30/24. No discontinued order observed.

11-100.1-15(e)



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Resident #2 – 4/26/24 medication order for “Azithromycin take as directed” was an incomplete order and did not include dosage, frequency and any other special instructions for the antibiotics order.

11-100.1-15(e)

Resident #2 – 4/26/24 “Promethazine-DM 6.5mg/15/mg/5mL give 5mL orally Q4-6 hours PRN was an incomplete order that did not include indication for PRN medication,

11-100.1-15(e)

Resident #2 – 4/26/24 order for Benzonatate 200mg PO TID observed with no documentation in MAR from 5/3/24-5/31/24 then medication order not transcribed in MAR on June 2024 to October 2024. No discontinued order observed.

11-100.1-15(e)

Resident #2 – September MAR observed with “stool softener and stimulant laxative 50mg/8.6mg 1 tab PO once daily” and initialed as given once daily from 9/6/24-9/30/24, and 10/1/24. No MD signed order until 10/3/23 (day of inspection).

11-100.1-15(m)

Resident #2 – October 2024 MAR for 10/3/24 did not have initials that morning medications (Vit B12, Carvedilol, Vit D3, Losartan) were given and on 10/2/24-10/3/24 no documentation that stool softener was given at 0730.

11-100.1-15(b)

Bedroom #4 – Observed unlabeled Aleve bottle in bedside drawer.


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