

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  125026	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/08/2025
NAME OF PROVIDER OR SUPPLIER  Kuakini Geriatric Care, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  347 North Kuakini Street Honolulu, HI 96817	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>42160</p> <p>Based on interviews and record review, the facility failed to ensure a resident's right to inform the resident's representative in advance, of the risk and benefits of proposed treatment one of five residents (Resident (R)72) sampled for unnecessary medication(s). As a result of this deficient practice, residents receiving psychotropic medications are at risk for more than minimal harm.</p> <p>Findings include:</p> <p>Review of R72's Electronic Health Record (EHR) on 01/07/25 documented the resident's most recent quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/16/24, Section C. Cognitive Functioning, Brief Interview for Mental Status (BIMS) score was 6, indicating the resident's cognition is severely impaired. Review of Section GG. Functional Patterns documented the resident is dependent on staff for all care. Review of R72's Physician's Orders documented orders for: Trazodone hydrochloride (HCl) Oral Tablet 50 milligrams (MG) Give 0.5 tablet by mouth two times a day for dementia behavior and agitation (Started on 12/27/24); Seroquel Oral Tablet 25 MG (Quetiapine Fumarate) Give 25 mg by mouth two times a day hold if sleepy or respiratory rate is less than 11 (Started on 11/15/24); and Zoloft Oral Tablet 50 MG (Sertraline HCl) Give 1 tablet by mouth one time a day for anxiety (started on 11/08/24). Review of the EHR did not contain documentation of R72's representative's consent for the use of psychotropic medications. Review of the R72's profile in EHR documented Family Member (FM)5 is designated to make health decisions for R72.</p> <p>On 01/07/25 at 01:48 PM, conducted a concurrent interview and review of R72's hard chart and the unit's psychotropic medication consent binder. Review of the binder did not contain documentation that FM5 consented to use of Trazodone, Seroquel, or Zoloft. RN3 confirmed there were no completed documentation in R72's EHR, hard chart, or the unit's Psychotropic Consent binder for R72. RN3 reported FM5 is off-island and consents are obtained through email and the unit supervisor or Director of Nursing (DON) is responsible for emailing FM5.</p> <p>On 01/07/25 at 02:30 PM, conducted an interview with the DON. Informed the DON that there was no documentation related to FM5 giving written consent for R72 to receive Trazodone, Seroquel, or Zoloft or had been informed that the facility is currently administering these medications to the resident and there was no documentation FM5 was informed of the risk versus benefits for receiving these medications. DON reported the employee responsible for contacting FM5 is on leave and the facility is unable to provide documentation that FM5 was informed of, consented, and received education on the medications previously listed prior to administering the medication to the resident.</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37954</p> <p>Based on observations, record review and interviews the facility failed to develop and implement a care plan (CP) for two of 23 residents sampled. Resident (R) 89 for the use of oxygen and R38 for a urinary tract infection with extended spectrum beta lactamase (ESBL), a bacteria that is resistant to many antibiotics.</p> <p>Findings Include:</p> <p>1) On 01/05/25 at 11:56 AM interviewed R89 in her room. R89 was observed sitting up in her wheelchair and had a nasal cannula on that was attached to the wall oxygen. Confirmed with R89 that her oxygen (O2) was at 2 liters (L) which she reported is on at all times. Resident stated she was diagnosed with chronic obstructive pulmonary disease (COPD) [AGE] years ago and only the last 2 years she has had symptoms of shortness of breath and needing to use oxygen.</p> <p>Review of R89's Electronic Health Record (EHR) found physician order for Supplemental O2 2-4L/min by nasal cannula with humidifier continuous to keep sats &gt; (greater than) 90% every shift for COPD. Review of R89's CP dated 10/04/24 revealed the continuous use of oxygen order at 2-4 L for resident's shortness of breath related to her COPD was not in the care plan.</p> <p>On 01/08/25 at 11:37 AM a telephone interview was conducted with Nursing Assessment Specialist (NAS) 1. Inquired if R89's oxygen use should be included in the resident's baseline and ongoing care plan. NAS1 confirmed R89 had a doctor's order for oxygen and that oxygen use should be included in R89's care plan. Surveyor asked NAS1 to look at R89's CP for oxygen use for COPD and she confirmed the continuous oxygen use was not included on the resident's care plan.</p> <p>On 01/08/25 at 12:04 PM interviewed the Director of Nursing (DON) regarding R89's CP. Informed DON R89's continuous use of oxygen was not on her CP. Inquired if this is something that should be on R89's CP and DON confirmed this should have been included.</p> <p>2) During a review of R38's EHR, he was readmitted to the facility on [DATE] and received antibiotics for a UTI intravenously three times a day for Sepsis due to acute pyelonephritis (inflammation of the kidney), ESBL/UTI until 01/03/25.</p> <p>Review of R38's CP revealed the focus included . staff utilize enhanced barrier precautions (EBP) to care for resident related to history of ESBL which was Created and Date Initiated on: 10/04/24. The goal for this focus states Resident will be free from ESBL infection through review date of target date: 04/05/25.</p> <p>Interventions included:</p> <p>a. Cart set up outside of patient's room and stocked with appropriate personal protective equipment (PPE) and trash can inside the room for discarding used PPE items or soiled items.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. Educate resident and residents' family/visitors on enhanced barrier precautions and when to utilized.</p> <p>c. Place an enhanced barrier isolation sign on resident room door.</p> <p>d. Staff will wear gown and gloves when performing high contact activities such as dressing, bathing, transferring, providing hygiene, changing linens, toileting, performing device care, or wound care.</p> <p>On 01/07/25 at 12:57 PM interview was done with Certified Nurse Aide (CNA) 25 outside of R38's room. Inquired if CNA25 uses EBP with R38 when working with him since he had been positive for ESBL. CNA stated no that there is no sign. Surveyor observed at this time there was no signage outside of R38's room and no cart with PPEs.</p> <p>On 01/08/25 at 10:49 AM interviewed DON and asked her about R38's CP for EBP use due to his history of ESBL. DON confirmed R38 has a CP for EBP due to his recent UTI with ESBL. She confirmed staff should be using PPEs and a sign should be up outside the room door and cart should have been outside of the room with PPEs.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47783</b></p> <p>Based on interviews and record review, the facility failed to implement interventions to treat one of one Resident (R)79 in the sample for constipation. The deficient practice may affect the resident's quality of life due to increased pain and discomfort.</p> <p>Findings include:</p> <p>R79 was a [AGE] year-old resident admitted on [DATE] for long-term care. Diagnoses included but not limited to dehydration, muscle weakness and constipation.</p> <p>On 01/06/25 at 10:25 AM, an interview was conducted with R79 in her room. R79 said she has constipation at times since she is less active now. Asked R79 if she takes any stool softeners, to which she replied, Yes. but does not recall how often.</p> <p>Review of R79's Electronic Health Record (EHR) was conducted on 01/07/25. R79 had the following laxatives (medications that treat constipation) ordered: Senna 8.6 milligram (mg) tablet at bedtime, Lactulose 20 grams (gm) as needed if no bowel movement (BM) for two days, and Bisacodyl Suppository 10 mg if no BM for three days.</p> <p>Review of R79's Bowel Elimination log in the EHR revealed that on the following days, she did not have a BM: 12/14/24 to 12/15/24 (two days); 12/18/24 to 12/20/24 (three days), 12/26/24 to 12/27/24 (two days); and 01/01/25 to 01/03/25 (three days).</p> <p>Review of the Medication Administration Record (MAR) for December 2024 and January 2025 revealed that Lactulose was not administered for both months when R79 did not have BM for two days.</p> <p>On 01/07/25 at 09:11 AM, concurrent interview and record review was conducted with Registered Nurse (RN)6 at the third-floor nurse's station. Asked RN6 if R79 ever complained of being constipated. RN6 said there were instances and looked at the Bowel Elimination log in the EHR. Asked if laxatives were administered as ordered when R79 did not have any BM. RN6 reviewed the MAR and acknowledged some doses were missed in December and January when R79 did not have BM for 2 days. RN6 said, She's supposed to get Lactulose after two days without BM. When asked if R79 refused the medication when offered, RN6 said there was no documentation in the MAR that R79 refused.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>47783</p> <p>Based on observations and interviews, the facility failed to provide appropriate care and services to prevent complications of enteral feeding (a way of delivering nutrition directly into the stomach or small intestine) for three of the 23 sampled residents (Resident (R)74, R50 and R59). The facility did not ensure the equipment used were properly cleaned and maintained. This deficient practice has the potential to put residents on enteral feeding at risk for preventable complications.</p> <p>Findings include:</p> <p>1) On 01/05/25 at 08:46 AM, initial screening of the residents was conducted. R74 was observed lying in bed with head elevated. A pole was next to her bed with a feeding pump attached. A plastic container filled with liquid enteral feeding formula was connected to the feeding pump. Observed the feeding pump, base of the pole and floor had some residue of dried formula.</p> <p>On 01/06/24 at 09:01 AM, observed R74 lying in bed with head elevated. The drops of dried-up formula were still on the pump, base of the pole and floor. Returned to R74's room at 10:37 AM and drops of dried-up formula were still observed while the pump was running.</p> <p>On 01/06/24 at 03:37 PM, a concurrent observation and interview was conducted with Patient Care Coordinator (PCC)3 in R74's room. Showed PCC3 the drops of dried formula that were still on the feeding pump, base of pole and floor. PCC3 acknowledged that it does not look sanitary and could attract insect and other pests that could carry pathogens (organisms that cause diseases). PCC3 then proceeded to wipe off the dried-up formula.</p> <p>37954</p> <p>2) On 01/07/25 at 09:30 AM observed Registered Nurse (RN) 44 prepare medications for R50 to be given via G-tube. RN44 stated she was going to start R50's gastrostomy tube (G-tube) feeding after giving his medications. While in resident's room observed a pole next to his bed with a feeding pump attached. A plastic container filled with liquid enteral feeding formula was connected to the feeding pump. Surveyor showed RN44 the area on the feeding pump and pole that was soiled. Inquired of RN44 who is responsible to take care of the feeding pump and clean it. RN44 stated night shift takes care of it. RN44 tried to wipe the feeding pump and commented that it was dried on and hard to get off.</p> <p>On 01/08/25 at 09:04 AM an interview was done with the charge nurse, RN55. Inquired with the charge nurse who is responsible to process the feeding pumps and clean them. RN55 stated all the staff are to clean the machine when it gets dirty, the task is not assigned to anyone. Surveyor told the charge nurse that there is dried on formula on the poles the feeding pump hangs from and on the feeding pumps themselves.</p> <p>42160</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3) On 01/07/25 at 09:56 AM, conducted an observation of R59 lying in bed with a liquid filled bag of enteral formula which was connected to a feeding pump. The feeding set loop area of the pump was caked in a thickened layer of old feeding formula. A divided plastic tray positioned below the feeding pump had dried splatters of feeding formula.</p> <p>On 01/08/25 at 10:15 AM, observed the feeding pump had been cleaned and inquired with RN3 about the clean feeding pumps. RN3 confirmed the feeding pumps on the fourth-floor unit had been cleaned due to the soiled surfaces.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37954</b></p> <p>Based on observations, record review and interviews the facility failed to properly label oxygen tubing when it was initiated for three of four Residents (R) 89, R19 and R216 sampled for respiratory care. The deficient practice placed the residents at risk of facility acquired respiratory infections.</p> <p>Findings Include:</p> <p>Cross Reference to F656 Develop/Implement Comprehensive Care Plan</p> <p>1) On 01/05/25 at 11:56 AM an interview was conducted with R89 in her room. R89 was observed sitting in her wheelchair with a nasal cannula which was hooked up to the oxygen (O2) in the wall. Inquired of R89 if the oxygen was on and she confirmed it was on and at 2 Liters per minute (LPM) at all times for her shortness of breath due to her diagnosis of chronic obstructive pulmonary disease (COPD). Inquired of resident when does staff change the nasal cannula and she stated staff changes it out when she asks them to, when it gets dirty or wet inside the tubing. During the interview surveyor and R89 did not observe any sticker with the date the O2 tubing was implemented.</p> <p>Review of R89's Electronic Health Record (EHR) found she was admitted to the facility on [DATE] and her diagnoses include, but are not limited to, chronic obstructive pulmonary disease with (acute) exacerbation (persistent respiratory disease with respiratory symptoms significantly worsening); acute respiratory failure with hypoxia (not enough oxygen in the blood); acute respiratory failure with hypercapnia (too much carbon dioxide in the blood); emphysema (air sacs of the lungs are damaged), unspecified; and pulmonary fibrosis (scarring and thickening of the tissue around and between the air sacs in the lungs), unspecified.</p> <p>Review of R89's Admission Minimum Data Set (MDS) with an assessment reference date of 11/05/24 found she had a Brief Interview for Mental Status (BIMS) with a score of 15 out of 15 identifying her as cognitively intact. Review of R89's physician orders found an order for Supplemental O2 (oxygen) 2-4L/min by nasal cannula with humidifier continuous to keep sats &gt; (greater than) 90% every shift for COPD.</p> <p>On 01/06/25 requested and received oxygen use policy from facility Administrator.</p> <p>On 01/08/25 reviewed facility policy Respiratory Delivery Devices dated 01/24, Purpose: To set guidelines for the use of respiratory delivery devices in the facility which include nasal cannula, non-breather [sic.] mask, oxymizer pendant and bland aerosol administration. Scope: All qualified and trained Personal staff. Policy: Qualified and trained personal will utilize, treat, and monitor use of these respiratory delivery devices. Procedure: A. Nasal Cannula (1/4 - 6 LPM) . 3. Change nasal cannula weekly and PRN soiled.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/08/25 at 08:47 AM interviewed Registered Nurse (RN)33 outside of R89's room and inquired who changes the nasal cannula tubing and when is it done. RN33 stated night shift usually changes the tubing and sterile saline for residents on O2. They usually change it on Fridays. At this time inquired of R89 about her nasal cannula and she stated staff did change out her tubing on Sunday 01/05/25 when she asked them about it, after our first interview before lunch. R89 stated the sticker came off and she was able to put it on her bedside table. Sticker was dated 01/05/25 and timed at 1400 (02:00 PM).</p> <p>On 01/08/25 at 12:04 PM an interview was conducted with the Director of Nursing (DON). Inquired who changes the nasal cannula for those residents receiving O2. She confirmed the nasal cannula is switched out weekly by staff and as needed when it gets dirty. Inquired of DON if staff label the new tubing with dates and DON confirmed the nasal cannula tubing and bottle of sterile water should have had dates on them.</p> <p>38870</p> <p>2) On 01/05/25 at 02:10 PM observation in R19's room. R19 was lying in his bed with Oxygen (O2) at 3 Liters per minute (LPM) via trachea collar and connected to an aerosol bottle with a blue tube. There was no label on the blue tubing with a date to indicate when it was changed.</p> <p>Quarterly Minimum Data Set (MDS) with an assessment date of 07/19/24 was reviewed on 01/06/25. R19 is a [AGE] year-old male with a diagnosis that includes respiratory failure requiring Oxygen therapy and Tracheostomy care.</p> <p>Treatment Administration Record (January 2025) reviewed on 01/06/25. Apply trachea collar daily.</p> <p>On 01/08/25 at 11:30 AM, interviewed the Director of Nursing (DON) in her office with the Administrator. The surveyor asked the DON how often the respiratory tubing is changed and by whom. The DON discussed that the tubing is changed on night shift every Friday and that the tubing should be labeled to indicate that it was changed.</p> <p>Facility Respiratory Delivery Devices policy 01/2024 was reviewed on 01/06/25. C. T-Piece/Trach Collar with Aerosol (21-100% Fio2, Set Flow 6-10 LPM) .6. Change nebulizer, tracheostomy collar, and tubing set up daily and as needed (PRN).</p> <p>3) Observation on 01/05/25 at 02:45 PM in R216's room who is on droplet precautions. R216 was lying in bed with his eyes closed and observed to have a deep productive cough. He was wearing a nasal cannula (NC) for O2 delivery. Observation of the O2 meter on the wall behind the head of the bed was not registering (in the off position). Observed the O2 tubing was not labeled with a date when the O2 tubing was changed.</p> <p>Observation and interview with Registered Nurse (RN) 25 in R216's room on 01/05/25 at 03:30 PM. The surveyor asked RN25 what the concentration of O2 is ordered for R216. RN 25 looked at the meter and said it's not on, but it's supposed to be at 2 L. RN25 turned the dial on the O2 meter until it reached 2 L. The surveyor asked RN25 when was the tubing was changed, by who and how often. She replied, its changed weekly by the Nursing staff, then looked closer at the tubing and said, there should be a label to note the date it was last changed, but there isn't one.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37954</p> <p>Based on observation and interview the facility failed to assure kitchen staff using the dishwasher waited for the water temperature to raise to 180 degrees Fahrenheit (F) or more during the final rinse cycle before processing the dishes from the conveyor belt, placing them on the storage racks of clean dishes, failing to assure dishware and silverware were heat sanitized. This deficient practice puts all residents and staff, who eat their meals at the facility, at risk for foodborne illness.</p> <p>The State Agency (SA) identified an Immediate Jeopardy (IJ) at S483.60 (F812) on 01/05/25 at 08:44 AM.</p> <p>Findings Include:</p> <p>On 01/05/25 at 08:43 AM an initial tour was conducted with Food Services Supervisor (FSS)1. During initial tour of the kitchen found the kitchen uses a dishwasher with high temperatures to sanitize their dishware and silverware. Review of facility log for the dishwasher stated Standards: Wash - 140-160 degrees F and Final Rinse - 180-190 degrees F. If temperature is above or below range, please inform the supervisor. Logs of temperatures written in for 01/01/25 - 01/04/25 were all within the standard temperatures.</p> <p>Observed dishwasher at 08:44 AM with dishes loaded on the conveyor belt moving through the dishwasher and kitchen staff unloading the dishes onto a rack. During this time, the dishwasher temperature was checked by surveyor and the final rinse was at 172 degrees F. Inquired of the FSS1 what the final rinse temperature was at, and she stated 172.</p> <p>Inquired with the Food Service Worker 1 who also confirmed the temperature was at 172 degrees F. Inquired with Food Service Worker (FSW) 2 what the final rinse has to be at for the dishes to be sanitized and she did not respond, FSW2 continued to unload the dishes that had gone through the dishwasher.</p> <p>Inquired with FSS1 what the final rinse has to be at, and she told staff to stop what they were doing. She stated the final rinse has to be 180 degrees or more. Inquired with FSS1 if the dishwasher uses a chemical sanitizer to clean the dishes and she said it is done by heat. FSS1 showed surveyor where the dishwasher detergent was dispensed from that leads to the dishwasher and also showed the Temp Rinse All Temperature Drying Agent.</p> <p>On 01/05/24 at 10:00 AM returned to the kitchen to meet with the Administrator to discuss findings about the dishwasher use. Reviewed dishwasher detergent with Administrator who confirmed the Micro-Pak detergent by microTECH concentrates is not a sanitizer and he also confirmed the Temp Rinse All Temperature Drying Agent is not a sanitizer.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Kuakini Geriatric Care, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  347 North Kuakini Street Honolulu, HI 96817	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>On 01/05/25 at 10:35 AM, the facility Administrator was notified in writing of the IJ and provided with the IJ template. Administrator signed the template to attest receipt of the notice. The facility failed to follow the proper sanitizing practices for the dishes and silverware to prevent the outbreak of foodborne illnesses as evidenced by final rinse temperatures of the water in the High Temperature Dishwasher (using heat sanitization) that were below the temperatures recommended for safety by the U.S. Department of Health and Human Services, Public Health Services, Food and Drug Administration Food Code (<a href="https://www.fda.gov/media/110822/download">https://www.fda.gov/media/110822/download</a>). Widespread serious harm is likely to all residents using facility dishware and/or utensils due to risk of transmission of enteral pathogens related to improper sanitization.</p> <p>On 01/05/25 at 01:04 PM requested kitchen use of dishwasher machine policy from Administrator which he provided.</p> <p>Review of policy titled Procedure for washing dishes by the use of a machine, Effective date: 01/10/18 states Purpose: To properly wash and sanitize dishware and silverware for its aesthetic value and to prevent the spread of harmful germs to patients, residents and staff.</p> <p>Scope: Food service workers</p> <p>Policy: All dishes, dishware and silverware shall be washed after each use. Dish machine [sic.] wash temperature should be 140-160 degrees F and final rinse temperature should be 180 degrees F and above.</p> <p>Procedure: .</p> <p>5. In the event of any of the following conditions, the dishwashing procedures shall be stopped immediately. The food service worker shall inform the supervisor who shall call the Plant Operations department or the service representative. The supervisor shall direct the staff to use the dish machine [sic.] at Hale Pulama [NAME]</p> <p>b. Final rinse temperature is below 180 degrees - call Plant Operations.</p> <p>On 01/05/25 at 11:55 AM the facility presented an acceptable plan for removal of the immediate jeopardy.</p> <p>On 01/06/25 at 04:00 PM, the SA finalized onsite verification that the IJ Removal Plan, provided by the facility and approved by the SA, had been implemented. Immediately the facility utilized one time use disposable plastic utensils and paper tableware (plates, cups and trays) till IJ was lifted. The facility was able to provide inservice training with their kitchen staff on proper use of the dishwasher which included coverage of final rinse temperature to be reached when cleaning dishes in the dishwasher prior to processing dishes and placing them on the clean rack. Kitchen staff were reminded to notify the kitchen supervisor if the wash and rinse temperatures are not met when using the dishwasher. Facility consulted with vendor for sanitizer that could be used with heat sanitizing dishwasher but this was not something the vendor offers. Vendor informed Kitchen Manager the sanitizer would break down with the heat.</p> <p>Facility monitored residents for 72 hours for signs and symptoms of infection.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51868</b></p> <p>Based on observation, interview, and record review, the facility failed to implement the facility's infection prevention and control measures for three out of twenty-three resident sampled.</p> <p>a. Resident (R)23 and (R)38 who were on isolation precautions did not have signage outside of their rooms at the door.</p> <p>b. The facility failed to assure staff to use proper personal protective equipment (PPE) when delivering a meal to a Resident (R)72 who was on droplet precautions. This deficient practice placed everyone at risk for developing preventable infections and other adverse health complications.</p> <p>Findings include:</p> <p>1) R23 was a [AGE] year-old resident admitted to the facility for long-term care. Diagnosis included but not limited to Methicillin Resistant Staphylococcus Aureus, an infection that is resistant to many antibiotics, and had an order for contact isolation effective 08/03/24.</p> <p>On 01/05/25 at 10:57 AM, observed no signage was posted outside R23's room stating that he was on transmission-based precautions (TBP) instructing everyone to follow contact precaution and check with the nurse before entering the room.</p> <p>On 01/05/25 at 11:02 AM, an interview was conducted with Patient Care Coordinator (PCC)3 and confirmed that R23 is on TBP, and that signage should have been placed outside his door to alert everyone. When asked if facility is supposed to place the signage, PCC3 confirmed, Yes, that should be placed outside the resident's door.</p> <p>On 01/07/25 at 10:21 AM, an interview was conducted with Director of Nursing (DON) in her office and confirmed that a sign should always be placed outside resident's room if they're on isolation precautions to alert staff, family, and visitors to prevent spread of infections.</p> <p>Review of facility's policy on 01/07/25, Infection Control - Section 3.0 Body Substance Precautions stated, . a STOP sign is placed on the door to alert personnel and visitors to Check with the nurse before entering</p> <p>37954</p> <p>2) Cross reference to 656 Develop/ Implement Comprehensive Care Plan. Review of R38's electronic medical record found he returned to the facility and was readmitted on [DATE]. R38 had received antibiotics for a urinary tract infection (UTI) intravenously three times a day for Sepsis due to acute pyelonephritis and ESBL/UTI until 01/03/25 which was documented as completed on 01/03/25. Review of R38's Care Plan (CP) revealed staff are to utilize enhanced barrier precautions to care for resident related to history of ESBL. Interventions listed on R38's CP included Cart set up outside of patient's room and stocked with appropriate Personal protective Equipment (PPE) and trash can inside the room for discarding used PPE items or soiled items. Place an enhanced barrier isolation sign on resident room door.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/07/25 at 12:58 PM an observation was made outside of R38's room along with a concurrent interview with Certified Nurse Aide (CNA) 25. Surveyor observed inside and outside of R38's room and saw there was no signage or PPE cart posted outside of resident's room and no discard bin inside R38's room for used PPEs. Inquired of CNA25 where the EBP sign and PPE cart was and CNA25 stated he is not on EBP, she confirmed there was no sign and cart of PPEs outside of R38's room.</p> <p>On 01/08/25 at 10:49 AM interview with the Director of Nursing (DON) was conducted. Inquired about R38's CP which she confirmed has a CP for EBP due to his recent UTI with ESBL. She confirmed staff should be using PPEs and sign should be up outside the room door and cart should have been outside of the room with PPEs.</p> <p>42160</p> <p>3) On 01/05/25 at 11:50 AM, observed Certified Nurse Aide (CNA)32 in R72's room delivering lunch. There was signage on the entrance to R72's room documenting the resident was on Droplet Precautions. However, CNA32 only wore a surgical mask. Inquired with CNA32 as to why R72 was on droplet precautions. CNA32 reported R72 was on droplet precaution due to testing positive for Respiratory Syncytial Virus (RSV).</p> <p>On 01/08/25 at 10:30 AM, conducted an interview with the DON. Informed the DON of my observations and inquired what PPEs should staff wear while delivering a resident's meal who is on droplet precautions. DON confirmed staff should have been wearing a face-shield, gown, an approved mask, and gloves.</p>		