

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125066	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/17/2025
NAME OF PROVIDER OR SUPPLIER Kalakaua Gardens		STREET ADDRESS, CITY, STATE, ZIP CODE 1723 Kalakaua Avenue Honolulu, HI 96826	

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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42160</p> <p>Based on observation, interviews and record review, the facility failed to ensure a comprehensive care plan was person-centered to maintain the resident's highest practicable physical well-being and the person-centered care plan was implemented for one resident (Resident (R)348) of 14 residents sampled. As a result of this deficient practice, dependent resident is at risk of more than minimal harm.</p> <p>Findings include:</p> <p>On 01/14/25 at 12:05 PM, conducted an observation of R348 in the resident's assigned room. R348 was lying in bed with a wedge partially under the resident's right hip area. Certified Nurse Aide (CNA)32 entered the room and provided peri-care to R348. R348 was dependent on CNA32 to move from side-to-side (left to right). After CNA32 rolled R348 onto the left side, observed an open area of skin with pink and white in the open wound-bed area on the right buttock. CNA32 reported that this is the first time she was aware that R348 had an open wound. Inquired with CNA32 what type of intervention were being implemented to prevent R348 from developing a pressure ulcer. CNA32 replied, It appears that we are placing a wedge under the resident's hip to off load the resident's weight. R348's Family Member (FM)1, also in the resident's room, R348 did not have an open wound or pressure ulcer on admission to the facility.</p> <p>On 01/15/24 at 10:05 AM, conducted a review of R348's Electronic Health Record (EHR). R348 was admitted to the facility on [DATE]. Diagnosis which include hemiplegia and hemiparesis following a cerebral infarction which affected the left side, pneumonitis due to inhalation of food, dysphagia, and atrial fibrillation.</p> <p>Review of R348's baseline care plan documented the resident requires two-person assistance while providing peri-care, and an observation was made of CNA32 changing the resident without the assistance of another staff. Review of R348's comprehensive care plan did not include the resident's functional abilities and amount of assistance needed from staff.</p> <p>(continued on next page)</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>The comprehensive care plan documented, R348 has potential for impairment to skin integrity related to fragile skin Moisture Associated Skin Damage (MASD) noted to Intergluteal Cleft with four interventions, Keep skin clean and dry. Use lotion on dry skin (Date Initiated: 01/14/25); Perform and document weekly skin checks. Notify MD/NP if skin integrity becomes compromised PRN (Date Initiated: 01/14/25); PT/OT to evaluate and treat as indicated, per MD order (Date Initiated: 01/14/25); and Treatment to be completed as ordered (Date Initiated: 01/14/25). The comprehensive care plan did not include interventions to prevent the open area from worsening or preventing R348 from developing a pressure ulcer in another area.</p> <p>Review of an assessment documented, on 01/13/25 at 01:28 PM, a Moisture Associated Skin Damage (MASD) Incontinence Associated Dermatitis (IAD) on the Intergluteal Cleft, in-house acquired; new 2.5-centimeter (cm) x 4.3 cm x 0.8 cm.</p> <p>On 01/17/25 at 10:20 AM, conducted a concurrent record review of R348's EHR and interview with the Director of Nursing (DON) with the Infection Preventionist (IP) in the DON's office. Informed DON of an observation of CNA348 providing care without assistance from another staff. Reviewed R348's care plan which documented the resident requires two-person assistance. Also, F348's functional abilities were not included in the care plan. DON reviewed R348's care plan and confirmed the comprehensive care plan was not person-centered to prevent the resident from acquiring MASD or a pressure ulcer. Also, DON confirmed the care plan did not include the functional abilities of the resident but should have.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>42160</p> <p>Based on interviews and record review, the facility failed to ensure a resident's (R)22 comprehensive care plan was revised with person-centered interventions after a significant change of condition assessment. As a result of this deficient practice, R22 was physically harmed, twice while left unsupervised in the bathroom and on the toilet.</p> <p>Findings include:</p> <p>(Cross Reference to F689 Accident/Hazards)</p> <p>On 11/17/24 at 08:57 AM, conducted a record review of R22's Electronic Health Record (EHR). Review of progress notes documented on 9/5/2024 at 12:45 AM, R22 was assisted to the bathroom by Certified Nurse Aide (CNA)65 who assisted the resident to the bathroom and onto the toilet. CNA65 left R22 unattended, and the resident fell from the toilet. CNA65 and Registered Nurse (RN)41 found the resident on the bathroom floor with her head against the adjacent wall. R22 reported to the staff that she hit her head hard and does not remember how or why she fell . Another progress note on 09/09/24 at 03:20 PM, documented the resident returned to the facility with a diagnosis of a right superior and inferior ramus fracture and skin tears to her right arm/forearm and right leg as a result of the fall on 09/05/24.</p> <p>Review of the resident's most recent quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/06/24, Section C. functional Abilities, C. Toileting Hygiene (the ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal) R22 requires partial/moderate assistance (helper does less than half the effort); Mobility Sit to stand: R22 requires partial/moderate assistance; F Toilet transfer (ability to get on and off the commode) R22 requires partial/moderate assistance.</p> <p>Review of the facility's Fall Scene Investigation Tool form dated 09/05/24 documented R22's loss of balance while getting off the toilet as the root cause of the fall. Staff's recommended interventions to prevent future falls documented R22 should be accompanied to the restroom and to not leave the resident unattended.</p> <p>Review of comprehensive care plan documented R22 is at risk for falls related to gait/balance problems and a history of multiple falls. After the fall on 09/05/24, where R22 sustained a pelvis fracture, the comprehensive care plan was not revised or updated. No interventions identified in the root cause or staff's recommendations to not leave the resident unattended in the bathroom were added to prevent a similar accident.</p> <p>Review of progress notes documented on 11/25/524 at 11:40 PM, R22 had a second fall in the bathroom. Again, R22 was assisted to the toilet, left unattended and had an unwitnessed fall. R22was found in a pool of blood which was coming from a cut on the resident's head. R22 also had a skin tear and multiple bruises. R22 reported she does not remember what happened. R22 was sent out to the acute hospital and returned with three sutures above the right eye.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/17/24 at 09:55 AM, conducted a concurrent record review and interview with the Director of Nursing (DON) regarding R22's falls and care plan revision. DON reviewed R22's comprehensive care plan and confirmed the resident's care plan was not updated to prevent a similar fall from occurring. DON also confirmed if R22 was not left unattended, the second fall could have been avoided.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>42160</p> <p>Based on interviews and record review, the facility failed to provide adequate supervision to prevent a second fall which could have been avoided for one (Resident (R)22) of 14 residents sampled. As a result of this deficient practice, the resident had a second fall which could have been avoided and sustained physical injuries.</p> <p>Findings include:</p> <p>On 11/17/24 at 08:57 AM, conducted a record review of R22's Electronic Health Record (EHR). Review of progress notes documented on 9/5/24 at 03:28 AM, a Certified Nurse Aide (CNA)65 answered R22's light at 12:45 AM and assisted R22 onto the toilet. CNA65 left R22 unattended, then heard a loud noise and the resident calling for help. CNA65 and Registered Nurse (RN)41 went into the bathroom and found the resident on the floor. R22 was lying on the right side, with her right arm under and behind the resident's back; the resident's head was against the wall (adjacent to the toilet), with wet briefs around her ankles and urine on the floor. R22 reported to staff that she hit her head hard against the wall, but she doesn't remember how or why she fell .</p> <p>A progress note on 09/09/24 at 03:20 PM, documented the resident returned to the facility with a diagnosis of a right superior and inferior ramus fracture and skin tears to her right arm/forearm and right leg as a result of the fall on 09/05/24.</p> <p>Review of the facility's Fall Scene Investigation Tool form documented R22's loss of balance while getting off the toilet as the root cause of the fall. Staff's recommended interventions to prevent future falls documented R22 should be accompanied to the restroom and to not leave the resident unattended.</p> <p>(Cross Reference to F657: Review/Revise Care Plan)</p> <p>Review of comprehensive care plan documented R22 is at risk for falls related to gait/balance problems and a history of multiple falls. After the fall on 09/05/24, where R22 sustained a pelvis fracture, the comprehensive care plan was not revised or updated. No interventions identified in the root cause or staff's recommendations to not leave the resident unattended in the bathroom were added to prevent a similar accident.</p> <p>On 11/26/24 at 08:57 AM, R22 was escorted to the toilet and assisted with pulling down the resident's brief. Staff left R22 unattended, then heard a loud noise and groaning. The registered nurse and staff entered R22's bathroom, saw the resident sitting on her right side in a puddle of blood which was coming from the resident's head. R22 had a skin tear to right knee, multiple bruises to the right arm, and a bruise forming on the right temple/cheekbone. Resident states she doesn't remember what happened, she thought she was just going to sit on the toile, then ended up on the floor. R22 was sent out to the acute hospital and returned with three sutures above the right eye.</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 01/17/24 at 09:55 AM, conducted a concurrent record review and interview with the Director of Nursing (DON) regarding R22's falls and care plan revision. DON reviewed R22's comprehensive care plan and confirmed the resident's care plan was not updated to prevent a similar fall from occurring. DON also confirmed if R22 was not left unattended, the second fall could have been avoided.		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47783</p> <p>Based on observation, interview, and record review, the facility failed to ensure the supplies used for Quality Control (QC) testing of the blood glucose meter (device used for testing blood sugar) were not expired or beyond their discard date. This deficient practice has the potential to affect all residents that need glucose testing.</p> <p>Findings include:</p> <p>On [DATE] at 09:04 PM, medication cart was inspected with Registered Nurse (RN)12. A pouch that contained the glucose meter, test strips and two QC solutions was on the top drawer of the cart. Noted a green sticker on the QC solutions that stated an open date of [DATE] and use by date of [DATE]. Asked RN12 how often the staff perform QC testing for the glucose meter. RN12 said QC testing is done daily by the night shift nurse. Showed RN12 the two QC solutions that was in the pouch with the glucose meter, RN12 acknowledged that both QC solutions were beyond their stated use by date and will be discarded. When asked if the staff used the QC solutions that were in the pouch with the glucose meter, RN12 reviewed the QC log and said Yes, it matches the lot number on the log.</p> <p>On [DATE] at 11:15 AM, Director of Nursing (DON) provided a document titled EvenCare G2 Glucose Control Solution that stated, . Discard any unused control solution 90 days after first opening or after expiration date .</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>39754</p> <p>Based on observations, staff interview and review of policy, the facility failed to follow up on an out-of-range temperature recording for one medication refrigerator out of one sampled. As a result of this deficiency, there was risk of decreasing the effectiveness for the stored medications.</p> <p>Findings include:</p> <p>During an observation of the Medication Refrigerator, on 01/16/25 at 08:50 AM, several medications were being stored under temperature control. Review of the refrigerator temperature log showed an out-of-range recording that was not followed up and not reported.</p> <p>Staff interview on 01/16/25 at 10:00 AM, Director of Nursing (DON) acknowledged the out-of-range temperature recording and that follow up should be done. DON also said the out-of-range temperature may have been recorded in error.</p> <p>Review of facility policy on Storage of Medication read; Policy, Medications and biologicals are stored properly, following manufacturers or provider pharmacy recommendations, to keep their integrity and to support safe, effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel or staff members lawfully authorized to administer medications . Procedures . Medications requiring refrigeration or temperatures between 2°C (36°F) and 8°C (46°F) are kept in a refrigerator with a thermometer to allow temperature monitoring. Medications requiring storage in a cool place may be refrigerated unless otherwise directed on the label . A temperature log or tracking mechanism is maintained to verify that temperature has remained within accepted limits . Medication storage conditions are monitored on a regular basis as a random quality assurance (QA) check. As problems are identified, recommendations are made for corrective action to be taken.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</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>51868</p> <p>Based on observation, interview and record review, the facility failed to follow food handling and storage practices in accordance with professional standards for food service safety. Unsafe and/or unsanitary food handling and storage practices have the potential to affect all residents, visitors and staff who have meals served by the facility, placing them at risk for serious complications from foodborne illness as a result of their compromised health status.</p> <p>Findings include:</p> <p>1) On 01/14/25 at 08:58 AM, an initial tour of the facility's kitchen and interview with the Dietary Director (DD) were done. Observed six boxes of various food items including spam, apple juice, garbanzos, and mayonnaise on the floor of the dry storage area. DD confirmed the boxes of food items should not be on the floor.</p> <p>2) On 01/14/25 at 09:05 AM, continued observation and interview of the facility's kitchen with the DD. Observed five boxes of various food items including imitation crab meat, potato roll, bread, and vegetables on the floor of the walk-in freezer. There was also an open plastic bag with food item DD identified as chicken nuggets on one of the shelves. DD confirmed delivery person did not properly store the boxes of food on the shelves. He stated, They were just delivered early this morning right before you guys (surveyors) came, and not supposed to be on the floor. DD immediately transferred the boxes of food into the appropriate shelves.</p> <p>3) On 01/14/25 at 09:18 AM, observed a large metal pan with food items partially covered with plastic wrap stored in the upper shelf inside the refrigerator. Dietary Aide (DA)1 identified the contents as cooked noodles and that it should not have been partially covered. DD stated, It was still hot when we placed it inside the refrigerator, so we left it partially covered.</p> <p>Review of the facility's policy and procedure on 01/14/25 titled Storing Food directed the staff to, . 3. Keep all food items on shelves that are at least 6 above the floor . 8. Store food in original container if the container is clean, dry, and intact. If necessary, repackage food in clean, dry, and airtight containers .</p> <p>4) On 01/14/25 at 09:20 AM, while inspecting the refrigerator close to the food preparation area with DD, observed a container labeled tuna salad and dated 01/08/25. At 09:55 AM, observed Dietary Aide (DA)2 with two small plates and four slices of bread in the food preparation area. Queried DA2 what she was about to prepare. DA2 said I'm going to make tuna sandwiches. Asked DA2 if she was using the tuna salad that was observed in the refrigerator earlier. DA2 said, We prepared the tuna salad on 01/08/25 and will be using it to prepare the sandwiches. Asked DA2 how long is the tuna salad good for, from the time it was prepared. DA2 said 6 days.</p> <p>Review of document posted on another refrigerator on 01/14/25, titled, Holding for Opened Food Items directed staff, . Tuna, Eggs & (and) Potato Salad - 4 (four) days .</p> <p>47783</p> <p>(continued on next page)</p>		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5) On 01/14/25 from 08:58 AM to 09:24 AM, initial tour of the kitchen area was conducted. Observed DD and DA1 not wearing required hair restraints. DD accompanied surveyors around the food preparation areas, food storages and dish washing area without any hair restraint. DA1 was working in the food preparation area and washing pots and pans in the sink close to the stove and oven. After the initial tour, shared observations with DD and he acknowledged that they should all be wearing hair restraints while in the kitchen area, and immediately proceeded to get a hairnet to cover his head.		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47783</p> <p>Based on record review and interviews, the facility failed to maintain a complete and accurate medical records for one of the residents (Resident (R)4) in the sample. This deficient practice has the potential to affect all the residents admitted to the facility.</p> <p>Findings include:</p> <p>R4 is a [AGE] year-old resident admitted to the facility on [DATE] for hospice care. During the review of R4's Electronic Health Record (EHR), noted baseline care plan under the Documents tab had a date of 10/15/24. Review of the document titled Baseline Care Plan revealed that it did not include the name of the staff who completed it and the date it was completed.</p> <p>On 01/15/25 at 02:40 PM, a concurrent interview and record review was conducted with Medical Records Specialist (MRS) at the third floor sitting area. Asked MRS what the facility's practice was when completing baseline care plans for newly admitted residents. MRS said the form used is part of the admission packet and is completed by the licensed staff on the day of admission. After completion of the form, it is scanned into the EHR by the MRS. Asked MRS if she was able to tell if R4's baseline care plan was completed within 48 hours of her admission. MRS looked in R4's EHR and was not able to find the completion date of the baseline care plan. MRS added that she leaves the facility at 04:30 PM so if the admission happens in the afternoon and the baseline care plan is not yet completed, it would be scanned into the EHR when she returns to work the next day. MRS confirmed that R4's baseline care plan was scanned into the EHR on 10/15/24, four days after admission.</p> <p>On 01/17/24 at 10:44 AM, a concurrent interview and record review was conducted with Registered Nurse (RN)12 at the nurses' station. Asked RN12 if she was able to tell when the baseline care plan for R4 was completed. RN12 opened R4's EHR and said it was completed on the admitted since she was the one that admitted the resident. Asked RN12 if there was documentation in the EHR that it was completed on 10/11/24. RN12 was not able to find any documentation on the form or in the progress notes that the baseline care plan was completed within 48 hours of admission. RN12 acknowledged that there was no documentation of who completed the form and when it was done.</p>		