Hawaii Dept. of Health, Office of Health Care Assuranc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125023	A. BUILDING: _____ B. WING _____	02/26/2016

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANAI COMMUNITY HOSPITAL	628 7TH STREET LANAI CITY, HI 96763

STATE OF HAWAII
DOH-OHCA MEDICARE

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4 000	11-94.1 Initial Comments A re-licensing survey was completed for this facility on 02/26/2016. The facility was licensed for 10 SNF/ICF beds, and there were 10 residents on the facility census at the entrance survey.	4 000	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: 1) By the end of the State of Hawaii Nursing Home Licensure Survey on February 26, 2016 - all due Minimum Data Set (MDS) assessments for the 10 residents at Lanai Community Hospital were completed and uploaded fully into the CMS QIES system. The entry and upload of two of the assessments were completed as part of the new hire orientation of the new Lanai Community Hospital – Long Term Care (LTC) Coordinator under the direction of the Director of Nursing (DON)/ Assistant Administrator (AA). 2/26/2016.	2/26/2016 2/26/2016
4 099	11-94.1-22(a) Medical record system (a) The facility shall have available sufficient appropriately qualified staff and necessary supporting personnel to facilitate the accurate processing, auditing and analysis, indexing, filing, and prompt retrieval of records, record data, and resident health information. This Statute is not met as evidenced by: Based on electronic medical record (EMR) reviews and staff interview, the facility failed to ensure that staff were trained to systematically document and access resident information. Findings include: [redacted]	4 099	2) The DON/AA was present at the Inter-Disciplinary Team Meetings noted in the Survey citations and on March 31, 2016 made late notations in the medical record as to the names of all staff present at the specific meetings for the respective residents. 3) All clinical staff were in-serviced on the appropriate place for documentation and reference for the Inter-Disciplinary Team Meetings and the Plan of Care within the electronic medical record on by March 31, 2016. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All of the residents were and have the potential to be affected by the defective practice of having only one person involved in the MDS process. Specifically all residents were reviewed to determine the required frequency and due dates for MDS submissions. Those identified as lacking were completed submitted assessments were completed. Feb 26, /2016. All clinical staff were in-serviced on the appropriate place for documentation and reference for the Inter-Disciplinary Team Meetings and the Plan of Care within the electronic medical record on by March 31, 2016.	3/31/16 3/31/16 2/26/16 3/31/2016

[redacted]

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4 099	Continued From page 1 [redacted]	4 099	WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: 1) The new LTC Coordinator was hired and brought on board February 18, 2016. [redacted]had begun orienting on the LTC unit, including the paperwork that [redacted]will be expected to be responsible for beginning with the MDS due next month (April 2016). [redacted]assisted with the most recent MDS which were submitted and accepted on time March 23rd. Next MDS will be due April 16, 2016. LTC Coordinator will complete the assessment, lock it and AA/DON will submit. In this way there will be 2 people involved and we will be able to help each other to get the MDS completed and submitted in a timely manner. A tracking tool is now (3/31/2016) part of the nursing unit calendar that identifies due dates for resident assessments and identification of when resident assessments were both completed and submitted. 2) all staff members participating in the Inter-Disciplinary Team will document their presence in the meeting notes – this will be monitored by the LTC Coordinator, 3) the LTC Coordinator will be periodically asking staff to navigate within the electronic medical record to demonstrate their knowledge of the location of the Plan of Care and Inter-Disciplinary Team Meeting notes HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: On a frequency of no less than monthly – the LTC Coordinator and DON/AA will meet to review the upcoming calendar of resident assessments and identify changes that may constitute a need for an additional resident assessment – thus assuring completion. Due dates for the MDS assessments will be made a part of the IDT process in order to document input from the team and monitor the timeliness of the MDS process. Additionally, with the review of completed assessments at the Interdisciplinary Team Meetings with names of staff participating. The LTC Coordinator will also report on completed and upcoming assessments and audits at the Quality Assurance Meetings. Next meeting scheduled for April 12, 2016	2/18/2016 3/23/2016 3/31/2016 4/12/2016

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4 099	Continued From page 2 [redacted]	4 099		
4 136	11-94.1-30 Resident care The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to: (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration; (5) Fall prevention; (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and	4 136		

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4 136	Continued From page 3 development when the facility provides care to infants, children, and youth. This Statute is not met as evidenced by: Based on medical record (MR) and electronic medical record (EMR) reviews and staff interviews, the facility failed to ensure that 1 of 9 residents (R#1) on the survey census sample, received the necessary care and services to maintain the highest practicable physical, mental and psychosocial well-being. Findings include: [redacted]	4 136	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: A review of ALL Lanai Community Hospital resident's medications ordered against supply on-hand was completed on March 28, 2016. This review noted that there were sufficient medications on hand and that none needed re-ordering at this time. Staff in-services were completed by March 31, 2016 that reviewed the policies & procedures and forms regarding "Event Reporting," which did not require updating, and the revised "Medication Administration" policy and procedure dated March 26, 2016. The requirement for staff compliance with these was emphasized for resident safety. After consultation with the Pharmacist it was decided to add the anti-seizure medications to the e-kit so they will be on site in case of potential for missed doses or need to increase dosage in a timely manner. 3/28/2016. New meds to arrive 4/4/2016	3/28/2016 3/31/2016 3/26/2016 3/28/2016 4/4/2016

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4 136	Continued From page 4 [redacted]	4 136	HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents have the potential to be affected by the deficient practice / failing to assure that necessary care is provided to assure the highest practicable physical, mental, and psychosocial well- being of residents. All staff are responsible to monitor and communicate appropriately in report and by filling out event report as soon as one medication is missed. All residents have the potential to be affected by this practice. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The Long Term Care Coordinator is assigned to monitor the medication orders for residents to assess for 1) changes in ordered medications, 2) the need to re-order medications, and 3) the documentation of medication administration. On a weekly basis the medication profile for each resident will be reviewed, action taken as necessary, and this assessment documented. Results of the review will be shared with the DON/AA no less than monthly and as needed, 3) completion of event reports for incidents regarding actual or potential events, including but not limited to missed medication doses. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: The LTC Coordinator will report on the completion of these assessments and the DON/AA will report on instances of events reported for discussion and prevention activities at the Quality Assurance Meetings. Next meeting April 12, 2016.	3/28/2016 4/12/2016

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4 136	Continued From page 5 [redacted]	4 136		
4 152	11-94.1-39(e) Nursing services (e) There shall be a policies and procedures manual that is kept current and consistent with current nursing and medical practices and approved by the medical advisor or director and the person responsible for nursing procedures. The policies and procedures shall include but not be limited to: (1) Written procedures for personnel to follow in an emergency including: (A) Care of the resident; (B) Notification of the attending physician and other persons responsible for the resident; and (C) Arrangements for transportation, hospitalization, or other appropriate services; (2) All treatment and care provided relative to the resident's needs and requirements for documentation; and	4 152	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Staff in-services were completed by March 30, 2016 that reviewed the policies & procedures and forms regarding "Event Reporting," which did not require updating, and the revised "Medication Administration" policy and procedure dated March 26, 2016. The requirement for staff compliance with these was emphasized for resident safety.	3/30/2016 3/26/2016

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4 152	Continued From page 6 (3) Medication or drug administration procedures that clearly define drug administration process, documentation, and authorized This Statute is not met as evidenced by: Based on medical record (MR) and electronic medical record (EMR) reviews and staff interviews, the facility failed to ensure that 1 of 9 residents (R#1) on the survey census sample, received the necessary care and services to maintain the highest practicable physical, mental and psychosocial well-being. Findings include: [redacted]	4 152	HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents have the potential to be affected by the deficient practice and all nurses will be responsible to monitor and communicate appropriately in report and by filling out event report as soon as one medication is missed. All residents have the potential to be affected by this practice. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The Long Term Care Coordinator is assigned to monitor the medication orders for residents to assess for) completion of event reports for incidents regarding actual or potential events, including but not limited to missed medication doses. The DON/AA began checking with staff no less than weekly about unusual occurrence's and verifying the completion of event reporting, HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: The LTC Coordinator will report on the completion of these assessments at the Quality Assurance Meetings. DON/AA will report on instances of events reported for discussion and prevention activities at the Quality Assurance Meetings – next meeting April 12, 2016	3/28/2016 4/12/2016

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4 152	Continued From page 7 [redacted]	4 152		

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4 160	Continued From page 9 [redacted]	4 160	HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents have the potential to be affected by the deficient practice and all staff are responsible to be compliant with performance expectations. All residents are at risk for food borne illness due to improper kitchen sanitation. All residents are at risk for food borne illness due to expired food. All residents are at risk for food borne illness due to improper sanitation of food contact surfaces. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Kitchen sanitation policy was revised 3/25/16 to include keeping the door closed to prevent contamination from the hallway, limiting kitchen access to dietary staff with hair nets worn, and not allowing personal beverages in the kitchen. Dietary staff was in-serviced 3/25/16 on the review of the Food storage policy including monitoring expiration dates, keeping food in its original packaging, keeping foods covered, labeling food packages with open dates, and using the food storage charts for guidance for use by dates for those foods without expiration dates on the package. Dietary staff was in-serviced 2/26/16 on proper sanitation testing, and the Dishwashing policy was revised 3/25/16 to including daily documentation of the ppm and immediate notification to the sanitizer company if re-calibration is needed. Dietitian or designee will complete a walk through monthly to ensure the kitchen sanitation improvements are sustained. Cook to complete monthly surveillance of all food storage areas to ensure all foods are covered and kept in its original packaging, labeled with an open date, and used by its expiration date on the package or by the food storage chart.	3/25/16 3/25/16 2/26/16 3/25/16

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4 152	Continued From page 8 [redacted]	4 152		
4 160	11-94.1-41(b) Storage and handling of food (b) Effective procedures to promptly and consistently clean all equipment and work areas shall be enforced. This Statute is not met as evidenced by: Based on observation and staff interviews the facility failed to store and prepare food under sanitary conditions. Findings include: [redacted]	4 160	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The Dietician in conjunction with the Dietary Manager developed staff educational in-services to address the requirements for : Dietary staff was in-serviced on 2/26/16 for kitchen sanitation improvements including: keeping the door closed to prevent contamination from the hallway, limiting kitchen access to dietary staff with hair nets worn, keeping all foods covered including coffee grounds and thickener until just before service, and not allowing personal beverages in the kitchen. Expired foods were discarded 2/26/16 Ecolab company visited the facility 3/8/16 to re-calibrate the sanitizer. Random audit completed March 30, 2016 found compliance with all areas of concern.	2/26/2016 2/26/2016 3/8/2016 3/30/2016

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4 160	Continued From page 10 [redacted]	4 160	HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: The DON/AA or Dietician will report on the completion of these assessments at the Quality Assurance Meetings. Next meeting scheduled for April 12, 2016	4/12/2016