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	125040	A. BUILDING: _____ B. WING _____	RECEIVED 07/01/2016

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LIFE CARE CENTER OF HILO	944 WEST KAWAILANI STREET HILO, HI 96720

2016 AUG -1 P 4:21
STATE OF HAWAII DEPT OF HEALTH MEDICARE

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4 000	11-94.1 Initial Comments A licensure survey was conducted by the State Agency from 6/28/16 through 7/1/16.	4 000	This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied.	
4 131	11-94.1-29(b) Resident abuse, neglect, and misappropriation (b) All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source or origin, and alleged misappropriation of resident property shall be reported immediately to the administrator of the facility, and to other officials in accordance with state law through established procedures. This Statute is not met as evidenced by: Based on record review and interview with staff member the facility failed to report an allegation of neglect to the State Agency. Findings include: [redacted]	4 131	**4 131** **08/15/16** *Point 1 – Corrective Action for the Affected Residents* [redacted] *Point 2 – Identification of Others Potentially Affected* The Executive Director and Director of Nursing reviewed the Reportable Events Log and no further concerns were identified. *Point 3 – Measures Put in Place; Systemic Changes* The Executive Director and Director of Nursing received directed in-service training on 7/22/16 regarding the facilities policies and procedures for reporting allegations of abuse/neglect to the State agency. Direct Care staff received directed in-service training on 7/21/16 through 7/26/16 on the facilities policies and	

[redacted]

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4 131	Continued From page 1 [redacted]	4 131	procedures for reporting allegations of abuse/neglect to the State agency. *Point 4 – Monitoring* The Executive Director will be responsible for ensuring that all allegations of abuse/neglect are reported timely to the State agency. The facility will keep a tracking log of all allegations. The log will be reviewed monthly by the Performance Improvement (PI) Committee until the committee determines that further review is no longer necessary. *Point 5 – Date Corrective Action Will be Completed* August 15, 2016	
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 development when the facility provides care to infants, children, and youth. This Statute is not met as evidenced by: Based on observation, record review, interview with staff members and review of the facility's policy and procedures, the facility failed to ensure each resident received the necessary care and services to attain or maintain the highest practicable physical well-being for 3 residents [redacted] Findings include: 1) Closed record review and interviews with staff members were done to investigate this complaint.	4 136	**4 136** *Point 1 – Corrective Action for the Affected Residents* [redacted]	**08/15/16**

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4 136	Continued From page 2 [redacted] Cross Reference to 11-94.1-29(b). This allegation of neglect was not reported to the State Agency. [redacted]	4 136	[redacted] *Point 2 – Identification of Others Potentially Affected* July 8 through July 11, a 100% skin audit was conducted by the nursing administration team to determine if there were any unidentified skin	

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4 136	Continued From page 3 [redacted]	4 136	conditions. Two additional skin issues were identified and corrected at the time of discovery. On July 11, 2016, a nurse consultant, reviewed the current listing of residents with excoriations and pressure ulcers to assess, evaluate associated treatments, to evaluate pressure relieving support surfaces for those residents. On July 11, 2016, the nurse consultant conducted a 100% audit of the physician wound treatment orders of each of the residents identified as having a skin condition in the facility wide audit. The physician orders were evaluated for clarity and accuracy. Clarification orders were written if the physician's order was unclear. On July 8th, 2016, the Unit Managers also compared the physician's order to the Treatment Administration Record to ensure that they matched, additionally, the treatment cart was audited to ensure that the treatment that was ordered was indeed in supply and available for the nursing staff to administer. No concerns were noted.	

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4 136	Continued From page 4 [redacted]	4 136	On July 13th through July 16th, 2016, a facility investigation of each resident who was identified in the 100% audit as having a skin condition was completed by the nursing administration team. The purpose of these investigations were to determine if the resident had any additional contributing factors that needed to be addressed by the clinical team; i.e decrease in mobility, history of ulcers, sensory impairments, any new medication changes, any support surface concerns etc… A total of 19 skin investigations were completed and reviewed by a nurse consultant for completeness and accuracy. Any new findings from these investigations were discussed with the resident's physician to determine if any changes to the resident's plan of care was needed. On July 8th and 15th, 2016, the interdisciplinary team conducted a 100% audit of each resident's careplans who were identified in the 100% skin audit, to ensure the careplan reflected current wound interventions to promote healing and	

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4 136	Continued From page 5	4 136	reduction of risk for acquiring a condition. On July 8th, 2016, the nursing administration team conducted a 100% audit of the most recent Braden risk assessments for each resident who was identified as having a skin condition on the 100% audit, to ensure that each resident had a current risk assessment in the medical record. *Point 3 – Measures Put in Place; Systemic Changes* On July 20th, 2016, the Director of Nursing was educated by the nurse consultant on the "ABC's of Wound Care". This education included, proper assessment of all types of wounds: anatomic location, size (cm), extent of tissue involvement (stage), characteristics of wound base (color), exudate, presence or absence of undermining, wound edges, condition of surrounding skin, and wound pain. In addition to assessment training, types of dressings for each classification of wound (pressure, moisture acquired, diabetic and vascular types) were also provided in this education to the Director of Nursing.	

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4 136	Continued From page 6 [redacted]	4 136	July 21, 2016 Unit Managers and charge nurses were provided the training on the "ABC's of Wound Care" by the Director of Nursing. July 21 through July 27, 2016, nursing administration provided education to all nursing staff on the importance of responding immediately to any skin issues that are brought to their attention, even if they feel it may have already been identified. They are to assess the area and validate if it is a new or existing skin condition and document their findings on the appropriate skin form "Non-Pressure Skin Condition Record and Pressure Ulcer Status Record" as well as make a descriptive nurses note addressing the characteristics of the wound. July 22nd, 2016 through July 27, 2016, the CNAs were educated by the nursing administration team and therapy team on the importance of proper peri-care and turning and repositioning residents. This education included: after each incontinent episode, the CNA will cleanse the resident with pre-moistened wipes, then the CNAs will apply a moisture barrier cream (non-zinc) to the resident's skin and then apply the incontinent brief. The CNAs will provide pressure relief to the residents by turning and repositioning per the resident's care	

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4 136	Continued From page 7 [redacted]	4 136	plan. Nursing administration also addressed the importance of communicating any skin issues that they identify to the charge nurse by using the "skin care alert" sheets. In addition to education, each CNA was required to perform a return demonstration to a member of the nursing administration team as how to complete proper peri-care. These return demonstrations occurred one on one with the CNA and Nurse Management and were completed from July 22 through July 27th, 2016. If any CNA was unable to receive the education and or conduct a return demonstration, they will be required to do so prior to working their next shift. The facility has a skin management policy that includes the following: All residents have a skin risk assessment completed upon admission, with a change in condition and quarterly. Newly admitted residents have a skin risk assessment completed weekly for the first four weeks and then quarterly. Those skin assessments that identify the resident as being moderate to high risk, are brought to the attention of the charge nurse for guidance on appropriate preventative interventions.	

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4 136	Continued From page 8 [redacted]	4 136	The facility has an alert process for any CNA or Nurse who identifies a skin issue with a resident, is to complete a "skin care alert" communication slip and hand it directly to the Unit Manager/Charge Nurse/Nurse supervisor for immediate attention. Once the nurse receives the communication slip, the nurse will assess the resident immediately to determine if this is an existing or new skin condition. The nurse will then document on an appropriate form in the medical record, "Non-Pressure Skin Condition Record and Pressure Ulcer Status Record". The nurse will also make a nurses' note describing the wound characteristics. The nurse will then inform the physician and responsible party if the skin issue is new or worsening. Upon notifying the physician, if the nurse receives any new orders, the nurse will note those orders on the TAR/MAR, make a nurses' note in the medical record and document this change on the 24 hour report for communication to the following shifts, will update the careplan as needed, obtain the newly ordered supplies/medications and stock the treatment cart with the supplies and will remove the old supplies.	

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4 136	Continued From page 9 [redacted]	4 136	The "Non-Pressure Skin Condition Record and Pressure Ulcer Status Record" are completed weekly by the Unit Manager to determine progression of healing, appropriateness of treatment and measurements. For all residents, a "Weekly Skin Integrity Data Collection" form is completed after the nurse conducts a head to toe skin assessment on each resident. If the nurse identifies any skin issue, the nurse is to notify the unit manager/supervisor upon discovery. Weekly the unit managers, therapy, DON and RD if possible, meet to review the residents who have current skin conditions to evaluate measurements of the wounds, progression towards healing, appropriateness of treatments, to identify new or different treatments and to ensure the careplan is current. Additionally, any residents whose risk for skin breakdown has increased will be reviewed at this meeting from a preventative stance. Daily, the Unit Manger/DON/Therapy, or designee will review the physician orders to ensure that any new physician orders for wound care are clear and	

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4 136	Continued From page 10 [redacted]	4 136	appropriately communicated to the interdisciplinary team members for follow through. Residents who are assessed as being at risk for skin breakdown, will be assisted with pressure relief by turning and repositioning. Residents will be assisted upon rising, before breakfast, after breakfast, before lunch, after lunch, before dinner, after dinner, bedtime and any time needed during sleeping hours. *Point 4 – Monitoring* The Unit Manager/Designee will conduct a weekly audit of all scheduled "Weekly Skin Integrity Data Collection Tools" for all residents to ensure they were completed timely and accurately. The results of these audits will be submitted to the Performance Improvement Committee for input and review through August 31, 2016. The Unit Manager/designee will complete a weekly audit of the following items for each resident who has a current skin condition: A skin assessment was complete according to policy, documentation	

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4 136	Continued From page 11 [redacted]	4 136	to support therapy involvement in the wound care, physician order for treatments, notification of physician and family of changes, careplan updated, pain is addressed before, during and after treatments, and observation of pressure devices in place. The Unit Manager/designee will collect and conduct a weekly audit of all of the "pink skin care alerts" communication slips received to determine that appropriate follow up by a nurse occurred timely, any areas of concern noted will be shared with the DON for further action. The results of this audit will be submitted to the Performance Improvement Committee for input and review through August 31, 2016. Minutes from the weekly skin meeting are submitted to the Performance Improvement Committee by the DON for input and review through August 31, 2016. The DON/designee will submit cases to the Performance Improvement Committee that need additional oversight and guidance on an as needed basis.	

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4 136	Continued From page 12 [redacted]	4 136	*Point 5 – Date Corrective Action Will be Completed August 15, 2016*	

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4 136	Continued From page 13	4 136		

[redacted]

On 7/1/16 at 10:45 A.M. the QAA (Quality Assessment and Assurance) interview was conducted with the Administrator and DON. The DON reported the facility has addressed skin issues. The facility discontinued the use of soakies, acquired pressure relieving mattresses, changed the moisture barrier cream (as they found some staff members applied the cream on too thickly) and provided inservice to staff. The facility will have the Unit Managers (UM) do the weekly skin rounds and currently have two UMs that have completed wound training.

The Administrator provided documentation entitled "Corrective Action Taken" following the survey team's exit conference. The corrective action includes: staff education (12/10 and 12/11/15) on the importance of identifying and reporting of any skin issues upon discovery;

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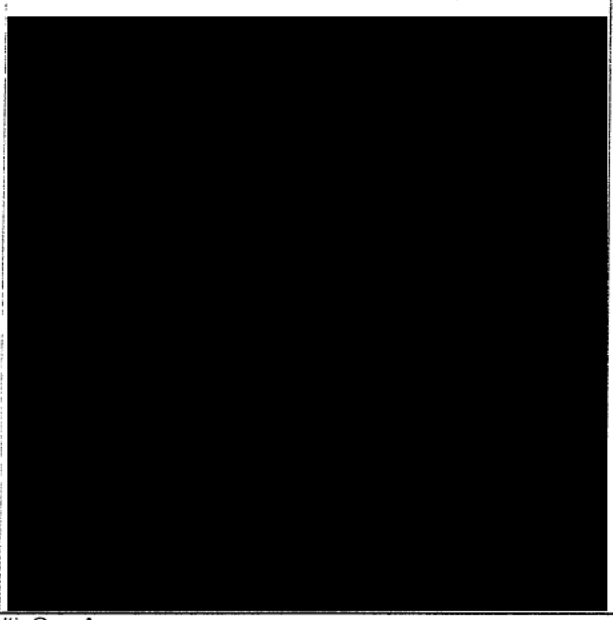
4 136	Continued From page 14 CNAs were educated on importance of utilizing INTERACT Stop and Watch form to alert/communicate to the nurse any skin conditions identified during their care; CNAs and nurses were educated on the importance of documenting all skin issues on their unit zone sheets upon discovery of any skin issue; nurses were educated on importance of conducting an assessment of all skin issues reported to them upon notification; nurses were educated on documenting all administered skin treatments in the treatment record; development of clinical competencies to accurately document weekly skin check, how to accurately document the initial data collection tool for each resident and how to properly assess a resident's skin condition; and CNA competencies were conducted to ensure the identification of any type of skin condition that may be presented and where to look for common areas of skin conditions on a mannequin. 	4 136		

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4 136	Continued From page 15 [redacted]	4 136		

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4 136	Continued From page 16 [redacted]	4 136		

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4 136	Continued From page 17 [redacted]	4 136		

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LIFE CARE CENTER OF HILO	944 WEST KAWAILANI STREET HILO, HI 96720

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4 136	Continued From page 18 [redacted]	4 136		

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4 136	Continued From page 19	4 136		

[redacted]

[redacted]

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4 136	Continued From page 20 [redacted]	4 136		
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage.	4 159	**4 159** *Point 1 – Corrective Action for the Affected Residents* The foods in the refrigerator (bread pudding, papaya) were covered and dated during the survey The dietary manager tossed the bag of mashed potato flakes that was torn and not dated with use by date during the survey	**08/15/16**

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4 159	Continued From page 21 This Statute is not met as evidenced by: Based on observations, interviews, and policy review the facility failed to store, prepare, and serve food under sanitary condition. Findings include: 1) On 6/28/2016 at 9:49 AM during a kitchen tour with the Director of Dietary (DD) observed 10 trays holding single serving pink bowls containing bread pudding cubes and 4 trays of papaya halves resting on single serving foam white plates. The 14 trays were not covered, the DD confirmed the plated food were for resident meals. The trays were shelved on holding carts in the walk in refrigerator. During the observation 2 other employees walked into the refrigerator passing the holding carts. When asked the DD stated the bread pudding was prepped 30 minutes ago and was to be served today, the papaya was to be served tomorrow 6/29/2016. The DD agreed that the food items should be covered. Observed in the dry pantry a box containing several bags labeled mashed potato flakes, one bag was torn opened with no used by date. The DD stated the bag should have been properly stored in a zip loc bag with an opened date. [redacted]	4 159	Dietary and direct care staff were inserviced by the SDC and CDM on 7/25/16 through 7/27/16 regarding our policy and procedures related to food safety, food storage, and infection control during meal service. Inservice included but was not limited to serving/assisting residents at meals, hand washing, appropriate use of sanitizer during meals, labeling and dating of foods, food storage, and policy for reported unacceptable temperatures for nourishment room refrigerators. All foods in the nourishment rooms that were not stored, dated/labeled correctly were tossed during the survey. All expired foods were tossed during the survey as well. The temperature gage in the North 3 nourishment refrigerator was adjusted so internal temperatures are below 38 degrees. *Point 2 – Identification of Others Potentially Affected* All residents who consume foods/fluids/snacks were determined to be at risk The CDM completed a sanitation/infection control/food safety audit of the kitchen and	

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4 159	Continued From page 22 [redacted] On 6/30/2016 at 7:59 AM observed in the North 1 nourishment refrigerator an opened bag of single serving ice cream cups with use by date 2/23/2016 and two single serving cups containing jello one without a date and another dated expired 6/10/2016. On 6/30/2016 at 8:14 AM in the North 3 nourishment refrigerator found 1 (one) Magic cup with an expired date 6/23/2016. Observed the refrigerator temp log sheet for June with recorded temperatures out of range 10 out of 30 days. The temperatures recorded by staff were: 6/8/2016 - 46 degrees; 6/13 and 6/14/2016 - 50 degrees; 6/15 and 6/19/2016 - 48 degrees; 6/20/2016 - 56 degrees; 6/22 and 6/23/2016 - 48 degrees; and 6/24 and 6/25/2016 - 50 degrees. The facility log document states temp. "Between 38 - 41 degrees F for refrigerator". The facility log instructions in the Comment Section states: "Describe any problems and actions taken to correct problem". Of the 10 dates there were 5 days when a comment was documented on action taken to correct the problem. When asked the UM #1 stated when the temperature is out of range there should be a comment made and a work order sent to maintenance to check the refrigerator if the problem is not resolved. An interview with the Maintenance Supervisor (MS) at 2:59 PM was held on the same day. The Maintenance Supervisor was shown the North 3 refrigerator log and asked if there were any work orders for the	4 159	nourishment rooms and dining room audit on 7/25/16 to ensure all foods were stored, prepared served and distributed per safely and per policy. No additional sanitation or infection control concerns were found upon inspection *Point 3 – Measures Put in Place; Systemic Changes* Use by date reference tools were posted on each refrigerator, freezer, dry storage area for staff to reference A new temperature tracking tool was implemented for the nourishment room refrigerators, specifically guiding staff on how to report out of range temperatures The dietary aide will be responsible for monitoring nourishment room refrigerators daily to ensure foods are stored per policy. This task was added to the dietary aides closing checklist. *Point 4 – Monitoring* The food service director/designee will conduct weekly audits for 30 days, monitoring to ensure foods are served, stored and distributed safely and staff are following policy and procedures. Results of the audits will	

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4 159	Continued From page 23 dates on the log when the refrigerator temperature was out of range. The MS reviewed the log and stated there was no work order. On 6/30/2016 at 8:30 AM in the North 2 nourishment freezer observed with the Unit Manager #1, 19 single serving cups of ice cream shelved on the freezer door. The cups were not in a bag and there were no dates on the cups. The UM #1 confirmed there were no dates on the cups.	4 159	be reported to the QAPI committee until sustained compliance has been achieved and maintained The Staff Developer, or designee will monitor dining at least monthly to ensure that staff are properly washing hands between residents. The results of the reviews will be documented and presented to the PI Committee until the PI committee determines that further review is no longer necessary.	
4 174	11-94.1-43(b) Interdisciplinary care process (b) An individualized, interdisciplinary overall plan of care shall be developed to address prioritized resident needs including nursing care, social work services, medical services, rehabilitative services, restorative care, preventative care, dietary or nutritional requirements, and resident/family education. This Statute is not met as evidenced by: Based on observation, interview and record review the facility failed to develop a comprehensive care plan with measurable objectives and timetables to meet a resident's medical, nursing needs for oral/dental care identified in the comprehensive assessment. For 1 of 20 sampled residents in the Stage 2 sample. [redacted] Finding includes: [redacted]	4 174	*Point 5 – Date Corrective Action Will be Completed* *August 15, 2016* **4 174** **08/15/16** *Point 1 – Corrective Action for the Affected Residents* [redacted] *Point 2 – Identification of Others Potentially Affected* The Director of Nursing, or designee will review all care plans to ensure that each resident has a care plan to address oral/dental care needs. *Point 3 – Measures Put in Place; Systemic Changes* Licensed nursing staff received directed in-service training on 7/21/16 through 7/25/16 specifically regarding the	

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4 174	Continued From page 24 [redacted]	4 174	necessity of care planning and addressing oral/dental needs for each resident. *Point 4 – Monitoring* The oral/dental needs of each resident will be reviewed at least quarterly as part of the regularly scheduled care plan conference. Director of Nursing, or designee will conduct a monthly audit of oral/dental care plans and the results of the monthly audits will be presented to the PI Committee monthly until the PI Committee determines that further review is no longer necessary. *Point 5 – Date Corrective Action Will be Completed* August 15, 2016	
			4 194	**08/15/16**
4 194	11-94.1-46(k) Pharmaceutical services (k) Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture,	4 194	*Point 1 – Corrective Action for the Affected Residents* Upon identification of this concern, the [redacted] was removed from the cart	

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4 194	Continued From page 25 ventilation, segregation, and security. This Statute is not met as evidenced by: Based on observations, interviews, and policy review the facility failed to dispose of expired medication accordingly and failed to properly label multiple dose medication bottles. Findings include: [redacted]	4 194	and discarded. The mislabeled [redacted] was discarded and the nurse was verbally instructed on the proper labeling of medication and maintenance of the temperature log for the medication refrigerator. The medications labeled with an open date but no year, and those open medications with no open date were discarded. *Point 2 – Identification of Others Potentially Affected* The Director of Nursing, or designee will review all medications for appropriate labeling in accordance with accepted professional standards. Any further concerns will be addressed immediately. *Point 3 – Measures Put in Place; Systemic Changes* Licensed nurses will receive directed in-service training to ensure drugs used in the facility are labeled in accordance with currently acceptable professional principles with specific attention given to medications that are discarded based on open dates. Licensed staff will receive directed in-service training on the proper storage and labeling of items in the medication refrigerators. This will include specific instructions on the maintenance and monitoring of medication refrigerator temperatures.	

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4 194	Continued From page 26 [redacted] [redacted] The facility policy on labeling of multidose medications "House Supplied (floor stock) Medications", states "3. Unless otherwise specified, the expiration date is limited to the expiration date on the original container or one year's time from the date of opening, whichever comes first." When asked the Unit Manager #1 agreed complete opened dates including day/month/ year should be written on multidose	4 194	*Point 4 – Monitoring* The Director of Nursing, or designee, will review all medications for proper labeling and storage at least monthly. The results of the reviews will be documented and a summary of the results will be presented to the PI Committee until the PI Committee determines that further review is no longer necessary. *Point 5 – Date Corrective Action Will be Completed* *August 15, 2016*	

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4 194	Continued From page 27 medication bottles to keep track of expiration dates.	4 194		